|   |   |                     | Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.  |
|---|---|---------------------|--|
|   |   |                     | State of Maryland / Department of Health and Mental Hygiene 15   50   State of Registrar Certificate of Death  |
| 2   | Physici<br>/Medic   | al                  | 1. Decedent's Name (First, Middle, Last)  Anna Elizabeth Dougial December 19, 2007 3:354  4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death  4c. County of Death  |
|   | Funeral<br>Director   | e:                  | 5. Social Security Number 6. Sex 1 M 2 Days 1 M 2 Days 1 M 2 Days 1 M 2 M 2 Days 1 Days 1 M 2 Days 1 Days 1 M 2 Days 1 Da |
| e Maryland  | Ba-f ehow   | ctor                | Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limit  Maryland Anne Arundel Pasadena 1□Yes 2 XIN   |
| h with th   | 23a or 2  | ai Dire             | 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21122 U.S.  |
| <b>5-0036</b><br>72 hours after death with the Maryland           | jiene.<br>rthan "natural", or iteme 23a or 28a-f ehow<br>Ite Medical Examinar mant be nutified at | by Funeral Director | 11. Marital Status  1 Never Married 2 Married 3 Married 4 Married 5 Married 5 Married 5 Married 5 Married 5 Married 5 Married 6 Married 7 Married 7 Married 8 Married  |
| 121<br>within   | r than "  | Completed           | 15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) 12th  16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)  Homemaker  16b. Kind of Business/Industry  Own Home  |
| yland 2   | od oth  | To Be C             | 17. Father's Name (First, Middle, Last)  Konstanty  Czajkowski  18. Mother's Name (First, Middle, Maiden Sumame)  Mary Budzko  |
|   | salth and Mer<br>n 27 le marke<br>er traumatic  |                     | 19a. Informant's Name/Relationship (Type, Print)  Marie Burns / Daughter  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  8347 Woodland Road Pasadena, Maryland 21122   |
| Baltimore,  |   |                     | 20a. Method of Disposition  1 Removal from State 4 Donation 5 Other (Specify)  20b. Place of Disposition (Name of cemetery, crematory or other place)  Holy Cross Cemetery 12/23/2005  Baltimore, Maryland  22c. Name and Address of Facility Gonce Funeral Service, P.A.  4001 Ritchie Highway Baltimore, Maryland 2122   |
| 60,<br>be executed III  | nysician<br>Medical<br>Kaminer<br>He pririal:Itansit  | icai Examiner       | 23a Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. Sonsi S  Due to (or as a consequence of):  Due to (or as a consequence oi):  Due to (or as a consequence oi):  Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence oi):  C. Due to (or as a consequence oi):  Due to (or as a consequence oi):  Due to (or as a consequence oi):  |
| Records, P.O. Box 687 The law requires that the death certificate | by the attending physitached for use as the   | Physician/Medic     | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9  Unknown  23c. If yes, outcome of pregnancy 1  Live birth 2  Fetal death 3  Ectopic pregnancy 4  Pregnant at time of death 5  Other (specify)  Month Day Year   |
| ords, P   | baan signad b<br>should ba det  | þ                   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause of death?  1   Yes 2   No 3   Probably 4   Unknow   |
|   | certificate has be<br>rector, page 2 sh   | Completed           | Chronic atrical fibrillation  24a. Was an autopsy performed?  Chronic atrical fibrillation  24b. Were autopsy findings available prior to completion of cause of death?  1 Yes 2000 1 Yes 2000   |
| Division of Vita or Attending Physician:                          | h.<br>After this<br>funeral di  | ation: To Be        | 25. Was case referred to medical examiner?    Yes   2 No   |
|   |   | Certification:      | 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |
| )<br>he Hospital  | n 24 hou<br>he Funer<br>pletely fill  | edical              | 29a. Certifier  (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |
| To the  | within 2 To the   | M                   | 29b. Signature and title of certifier  29c. License number  D 55391  De eem   Lev 19, 200  |
|   | Y   |                     | 30. Name and address of person who will leted cause of death (Item 23a) (Type, Print)  Ming Vi 3328 Lenson Avenue, Baltimore, Maryland 21227  31. Data filed (Astron. Day York)  |
| Tide  | Sta<br>Regist   |                     | 31. Date filed (Mohth, Day, Year)  32. Registrar's Signature   |

DHMH 17 Rev 1/2001

ORIGINAL

AVIS

To the Hospital or Atterwithin 24 hours efter dea To the Funeral Diractor completely filled in by the

| sion of Vital Records, P.O. Box 6876 | ending Physiclan: The law requires that the death certificate beath. | tor: After this certificate has been signed by the attending physic<br>the funeral director, page 2 should be detached for use as the b |  |
|--------------------------------------|--|---|--|
| o uo                                 | ding Ph<br>h.  | After th<br>funeral   |  |
| S                                    | tendin<br>leath.   | the   |  |

1 🕱 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

4 - Homicide

29b. Signature and title of certifier Manpiect

Mangat

P 19926

29d. Date signed (Month, Day, Year) DECEMBER 18,2005

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CATON AVE, BALTIMORE MD. 21229 MANGAT, 900 A MANPREET 31. Date filed (Month, Day, Year)

State Registrar

DHMH 17 Rev 1/2001

cai



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend item / per inf 2850 12-23-05 vt

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** December 19, 2005 10:20 AM Warren Eaton /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Gilchrist Hospice Center Towson Baltimore If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral**  Birthplace (State or Foreign Country) 1₩ 2□ F 100 Director Nov 23, 1904 213-01**-**7927 Maryland Usual Residence of Decedent deeth with the Maryland 10a. State 10b. County 10c. City, Town or Location item 27 is marked other then 'naturel', or items 23e or 28e-f show other treumstic event, the Modical Examiner must be notified at 10d. Inside City Limits 1√2 Yes 2 No Director MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8800 Walther Blvd #1116 21234 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates: 142-46 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No þ 3 Widowed 4 Divorced Specify: white Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry d 2 should be filed within 7. h and Mental Hygiene. 7 ie marked other then "n Elementary/Secondary (0-12) Coltege (1-4or 5+) 10 auto mechanic automotive 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be James Wesley Eaton Phoebe Abigail West 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Importent: If item 27 is eny injury or other tret once. 8800 Walther Blvd #1116 Baltimore, MD Irene Eaton/spouse ATON 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 21. Signatur of Funerat ervice Licensee Royald S. Wad 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Director man 11 Baltimore, MD 21201 23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death tmmediate Cause (Final **Physician** disease or condition resulting in death) welk /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, teading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine attending physician and I for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Records, P.O. Box 68760 Physician/Medical tF FEMALE: 23c. tf yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown ete has been signed l page 2 should be det Part tl. Other significant conditions contributing to death but not resulting in the underlying cause given in Part t, 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? certificate 1 ☐ Yes 2 ☐ No Division of Vital 1 Yes 2 No To the Hospitel or Attending Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No မှ 1 Inpatient 2 ER/Outpatient this 3□ DOA After thi 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of Certification: 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation Injury within 24 hours after death.

To the Funerel Director: Al
completely filled in by the fu 1 Yes 2 No 6 Could not be determined 3 🗌 Suicide 28e. Ptace of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and Jitle of certifier 29c. License number 29d. Date signed (Month, Day, Year) 140 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Chale St. Calto and 2120x 31. Date filed (Month, Day, Year) 32 Registrar's Signature State DEC 23 Registrar 2005

|  |                  | 1 - For<br>State<br>Registrar   | State of Ma   | arylan                                |                                 | artment of                                   |                                      | and M           | lental Hy                       | giene<br>Reg. No.            | 005                         | 41504  |
|--|------------------|---|---|---------------------------------------|---------------------------------|--|--------------------------------------|-----------------|---------------------------------|------------------------------|-----------------------------|--|
| Physic   | ian              | Decedent's Name (First, Middle,   |   |                                       |                                 |  |                                      |                 | 2. Date of De<br>Month          | Day                          | Year 2005                   | 3. Time of Death  7:08A M                            |
| /Med<br>Exami  |                  | Rebecca A. E1  4a. Facility Name (If not institution,   |   |                                       |                                 | 4b. City, Town                               | n, or Location of                    | of Death        | Decem                           |                              | unty of Deat                |  |
|  |                  | Holy Cross Ho   |   |                                       |                                 |  | er Spri                              |                 |                                 |                              | ntgome                      | ry   |
| Funera   |                  | 5. Social Security Number 213–56–8746   | . Sex 7. Ago<br>1  M 2  | e (In yrs. I<br>55                    | ast birthday)<br>Yrs.           | If Under 1 Ye<br>Months Da                   |                                      | 24 Hrs.<br>Min. | 8. Date of Bir<br>(Month, Da    | ay, Year)                    |                             | hplace (State or Foreign<br>untry)                   |
| Director   |                  | Usual Residence of Decedent   |   |                                       |                                 |  |                                      |                 | Nov. 1                          | , 1950                       | Mai                         | ryland   |
| lanylan<br>ehow  | _                | 10a. State 10b. County  |   | 10c. City                             | r, Town or Lo                   | cation                                       |                                      |                 |                                 |                              |                             | 10d. Inside City Limits 1 ☐ Yes 2 ☑ No               |
| d 21215-0036<br>filed within 72 hours after death with the Maryland<br>Hygiene.<br>ther then "nature!, or Items 23s or 28s-f ehow<br>int, tra Madical Exercitor must te notified at  | Funeral Director | Maryland Montgo   | omery   | Sil                                   | ver Sp                          | ring   | le .                                 |                 |                                 | 10g. Citizer                 | n of What Co                | L  |
| 3 with   | ā                | 3736 Bel Pre Ro   | ad. #4  |                                       |                                 | 20906  |                                      |                 |                                 |                              | d Stai                      | ,  |
| r death  | nere             | 11. Marital Status  | 12. Was Decedent Armed Forces?                                    | Ever in U.                            | S. 13.                          |  | of Hispanic Orig<br>Cuban, Mexican   | gin? (Spe       | ecify Yes or No<br>Rican, etc.) |                              | Race - Ame                  | nican Indian,  |
| 36<br>s afte   | by Fu            | 1 ☐ Never Married 2 ☑ Married<br>3 ☐ Widowed 4 ☐ Divorced   | d 1 ☐ Yes 2 🔯 N<br>If Yes, Give                                   | No                                    |                                 | 1 □ Yes 2 🗓 I                                |                                      |                 | , , , , ,                       |                              | ecity:                      | -  |
| Maryland 21215-0036 of 2 should be filed within 72 hours after the and Mental Hygiene.  77 is marked other then "nature!, or its traumetic event, tra Medical Examination.   | ted t            | 15. Decedent's  | Year or Dates:<br>Education                                       |                                       | 16a. Dece                       | dent's Usual Oc                              | cupation                             |                 |                                 | 16b. Kind                    | of Business/l               | nite   |
| 215<br>thin 7:   | Completed        | (Specify only highest Elementary/Secondary (0-12)   | grade completed) College (1-4or 5                                 | i+)                                   | (Give<br>lite.                  | kind of work do<br>DO NOT use re             | one during most<br>tired)            | t of worki      | ng                              | Unit                         | ed Sta                      | ates   |
| nd 212. Illed within Hygiene. other then   |                  | 17. Father's Name (First, Middle, La  | 1   |                                       | Admi                            | nistrat                                      | ive Ass                              |                 | nt<br>(First, Middle            |                              | rnment                      | t  |
| ~ o = o >  | o Be             | Ralph Raymond R   |   |                                       |                                 |  |                                      |                 | shman.                          | , maider 30                  | mamej                       |  |
| Shoul<br>ond Mo  | 5                | 19a. Informant's Name/Relationship  | 0   |                                       | 19b. Mailir                     | ng Address (Str                              | eet and Numbe                        |                 |                                 | er, City or To               | own, State, 2               | Zip Code)  |
|  |                  | Charles R. Elle   | rman/Husban   |                                       |                                 |  |                                      |                 |                                 | r Spri                       | ng, Ma                      | aryland 20906  |
| Baltimore, sernit. Peges 1 er Department of Hez mportent: If item moy Injury or othe 20ce.   |                  | 20a. Method of Disposition 1 🖾 Burial 2 □ Cremation 3   | ☐Removal from State   | 20b. Pi                               | lace of Dispo                   | sition (Name of<br>natory or other<br>Memori | place) D                             | ecen            | ate<br>aber                     | 20c. Locat                   | tion - City or              | Town, State  |
| Itimen rithmen |                  | 4 Donation 5 Other (Spe   |   | 1 41                                  | Pa:                             | rk.  | : Z                                  | 4, 2            | 005                             | Rocky                        | ille,                       | Maryland   |
| Bal<br>permi<br>Depa<br>Impo   |                  | 21. Signature   | Bonne   | M008                                  | 303 B                           | ethesda                                      | -Chevy                               | Chas            | e Inc                           | 7557                         | Wisco                       | neral Home/<br>onsin Avenue                          |
|  |                  | 23a. Part1. Enter the disease, or co<br>shock, or heart failure. List or  | omplications that caused  | the death                             |                                 |  |                                      |                 |                                 |                              |                             | Approximate<br>Interval Between                      |
| Physician  |                  | Immediate Cause (Final disease or condition   | Myocar  |                                       | Infar                           | ction  |                                      |                 |                                 |                              |                             | Onset and Death                                      |
| /Medical<br>Examiner   |                  | resulting in death)   | Due to (or as   | a consequ                             | ience of):                      |  |                                      |                 |                                 |                              |                             |  |
|  | -e               | Sequentially list conditions, if any, leading to immediate  | b. Obesit   |                                       | ience of):                      |  |                                      |                 |                                 |                              |                             |  |
| 3760, ate be executed hysiclen end ine burial-transit  | Examiner         | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events | s Smokin  | g                                     |                                 |  |                                      |                 |                                 |                              |                             |  |
| 1760, Ite be executed sysicien end ne burial-transit   | Ex               | resulting in death) Last  | Due to (or as   | a consequ                             | ience of):                      |  |                                      |                 |                                 |                              |                             |  |
| 876<br>cate b  | dical            |   | d   |                                       |                                 |  |                                      |                 |                                 |                              |                             |  |
| Box 68 eath certificat ettending phy   | Physician/Med    | IF FEMALE:<br>23b. Was decedent pregnant  | 23c. If yes, outcome  |                                       |                                 |  |                                      |                 |                                 | 23d                          | . Date of deli              | iverv  |
| death  | sicia            | in the past 12 months?<br>1 ☐ Yes 2 🖾 No  | 1□Live birth<br>4□Pregnant at<br>9□Unknown                        |                                       |                                 | Ectopic pregna<br>Other (specify             |                                      |                 |                                 |                              | Month                       | Day Year   |
| P.O.   | Phy              | 9 ☐ Unknown  Part II. Other significant conditions  |   |                                       | daine in about                  |  | in Date                              |                 | an Did                          |                              |                             |  |
| ds,<br>signe<br>dbe d  | d by             | raitii, Othor significant conditions  | s contributing to death bu  | ut not 1950                           | illing in the ui                | idenying cause                               | given in Parti.                      |                 |                                 |                              |                             | the cause of death?                                  |
| cord<br>w require<br>been si   | iete             |   |   |                                       |                                 |  |                                      |                 | 24a. Was                        |                              |                             |  |
| Rec<br>The lav   | Completed        |   |   | · · · · · · · · · · · · · · · · · · · |                                 |  |                                      |                 | auto                            | psy<br>prmed?                | prior to death?             | topsy lindings available completion of cause of 2 No |
| of Vital Records, Physicien: The law requires t  | BeC              | 25. Was case referred to medical examiner?  |   |                                       |                                 |  | 26. Place                            | of Death        | (Check only                     |                              | 10.163                      | 2 140  |
| Of V<br>Physic<br>this co  | 2                | 1 ☐ Yes 2 💢 No<br>27. Manner of Death   | Hospital:   |                                       | ER/Outpatien                    | L 3M DOA                                     |                                      |                 | me 5 ☐ Resi                     |                              |                             | cify)  |
| On oding Ih.   | tion             | 1 Natural 5 Pending 2 Accident investiga  | 28a. Date of Injur<br>(Month, Day                                 | Year)                                 | Injury                          |  | njury at<br>Work?<br>I □ Yes 2 □ I   |                 | 28d. Describe                   | now injury or                | curred                      |  |
| Division I or Attending efter death. Director: Afte  | Certification:   | 3 Suicide 6 Could no<br>4 Homicide determin   |   | ıry - At hoi                          | me, farm, stre                  | et, factory, offi                            | сө                                   |                 | 281. Location (<br>City or To   |                              | umber or Ru                 | ral Route Number,                                    |
| Di<br>ital or<br>ral Diu   | Ce               |   |   |                                       |                                 |  |                                      |                 |                                 |                              |                             |  |
| Division of Vital Records, P.O. Box 68 To the Hospital or Attending Physicien: The law requires that the death certifical within 24 hours eller death.  To the Funeral Director: After this certificate has been signed by the ettending phy completely tilled in by the funeral director, page 2 should be deteched for use as the  | edical           | 29a. Certifier 1 📉 Certifying (Check only 2 Medical E) one)   | Physician: To the best of caminer: On the basis of and manner sta | examinati                             | vledge, death<br>ion and/or inv | occurred at the<br>restigation, in m         | e time, date and<br>ny opinion, deat | d place, a      | and due to the ed at the time,  | cause(s) and<br>date and pla | d manner as<br>ice, and due | stated.<br>to the cause(s)                           |
| ro the<br>vithin ?<br>ro the   | Me               | 29b. Signature and title of certifier   | A III III III STA   |                                       | N                               | 29c. Lice                                    | ense number                          |                 |                                 | 29d. Date si                 | igned (Month                | n, Day, Year)  |
|  |                  | 1 / -   | hal   | M                                     | 77                              | n41  | 1624                                 |                 |                                 | Decem                        | ber 21                      | , 2005   |
| ×  |                  | 30. Name and address of person w  | / 1   |                                       |                                 | Print)                                       |                                      |                 |                                 |                              |                             |  |
|  |                  | Guy Patrick Mu:<br>31. Date liled (Month, Day, Year)  | rphy (M.D.  |                                       |                                 | t Glen                                       | Road,                                | Silv            | er Spri                         | ing, Ma                      | arylan                      | d 20910  |
| Regis  | tate<br>trar     | DEC 2 3 20  | )05 A. Hegistra   | ar s Signali                          | ADB9                            | de la  |                                      |                 |                                 |                              |                             |  |

|                     |  |                      | Flease   |  | indendie ink. Ensure  | •  | _                              |                                    |
|---------------------|--|----------------------|--|--|---|--|--------------------------------|------------------------------------|
|                     |  |                      | 1_ For State   |  | epartment of Health and   | Mental Hygie                               | ng nns                         | . 1505                             |
| _                   |  |                      | 1 - State<br>Registrar   |  | Certificate of Death  | Reg.                                       | No.                            | 1000                               |
|                     | Physici  | an                   | Decedent's Name (First, Middle, La   |  |   | 2. Date of Death<br>Month                  | Day Year                       | 3. Time of Death                   |
|                     | /Medi  |                      |  | illis tult   | on  | 12   | 18 05                          | 9:00 pm                            |
| 7                   | Examir   | ier                  | 4a. Facility Name (If not institution, giv   | e street and number)   | 4b. City, Town, or Location of Dea                                      | th MA                                      | 4c. County of Death            |                                    |
|                     |  |                      | horien Vur   |  | Daltimore   |  | NA                             |                                    |
| ı                   | Funeral  |                      | 5. Social Security Number 6. S   | Mu and   | rs. If Under 1 Year   If Under 24 Hrs<br>Months Days Hours Min          |  | 9. Birthpla                    | nce (State or Foreign              |
|                     | Director   |                      | Usuel Residence of Decedent  | 50   | 13.   | July 16,1                                  | 955 Mar                        | rylana                             |
|                     | land<br>wo   |                      | 10a. State 10b. County   | 10c. City, Town  | or Location   |  | 10                             | d. Inside City Limits              |
|                     | death with the Maryland<br>ms 23a or 28a-f show  | ţ                    | Maruland N/  | 4 Bal  | timore  |  |                                | 1 XYes 2 No                        |
|                     | r 28a  | Director             | 10e. Street and Number   |  | 10f. Zip Code   | 10g.                                       | Citizen of What Countr         | y?                                 |
|                     | 3a o   | DI                   | 1724 F 21H   | (St.   | 21218   |  | MSA                            |                                    |
|                     | deatl  | ner                  | 11. Marital Status   | 12. Was Decedent Ever in U.S.<br>Armed Forces?                   | 13. Was Decedent of Hispanic Origin? (                                  | Specify Yes or No-                         | 14. Race - America             |                                    |
| ဖွ                  | after<br>or Ite  | F                    | 1 ☐ Never Married 2 ☐ Married  | 1 Yes 2 No   | 1 ☐ Yes 2 Dan, Mexican, Pue   | to Hican, etc.)                            | Black, White, et               | ic.                                |
| 8                   | hours after<br>turel', or Ite  | d by                 | 3 ☐ Widowed 4 ☑ Divorced   | Year or Dates:   | TEL TES ZIDONO SPECITY:   |  | Specify: Bla                   | ick                                |
| Š                   | 72 h   | ete                  | 15. Decedent's Ed<br>(Specify only highest gra                                     | ducation 16a. I<br>de completed)                                 | Decedent's Usual Occupation<br>Give kind of work done during most of wo | nrking 16b                                 | . Kind of Business/Indu        | istry                              |
| 걸                   | within<br>ene,<br>than "   | Completed by Funeral | Elementary/Secondary (0-12)  | College (1-4or 5+)   | life. DO NOT use retired)   |  | 2016 00                        |                                    |
| 22                  | be filed within 72 hours after death with the Marylan<br>ital Hygiene.<br>od other then "neturel", or Items 23a or 28a-f show<br>event, the Medical Examiner must be notified at   |                      | 17. Father's Name (First, Middle, Last)  |  | 18 Mother's Na  | me (First, Middle, Maid                    | Selt-en                        | proyea                             |
| Maryland 21215-0036 | Id be 1<br>ental I<br>ked o  | o Be                 | Willia Eu  | ton  | Ella 1  |  | a chia V                       | F 14-                              |
| 2                   | should be<br>nd Mental<br>s marked o   | Ĕ                    | 19a. Informant's Name/Relationship (   | Type Printle   19h   | Mailing Address (Street and Number or R                                 | DUISE D                                    | NOSTICE Town State 7in (       | rullon                             |
| ĭ                   | s 1 and 2 should<br>f Health and Men<br>fem 27 Is marke<br>other traumatic   |                      | Mc Katring +   | Type, Print) (laughter) 19b.                                     | 729 Banzing   | - RID                                      | - H- Md                        | 21225                              |
| ē,                  | Heal<br>Heal<br>tem  |                      | 20a. Method of Disposition   | 20b. Place of  | Disposition (Name of  | Date 20c                                   | Location - City or Tow         | n, State                           |
| <u>o</u>            | Pages<br>nent of<br>int: If it   |                      | 1 Burial 2 □ Cremation 3 □ 1 □ Donation 5 □ Other (Specif                          | Removal from State   | , crematory or other place)   | 28/05                                      | wo d-11                        | 1001                               |
| Baltimore,          |  |                      | 21. Signature of Funeral Service Licer   | 11.115   | 22. Name and Address of Facility  | 1  | unaar                          | , Ma.                              |
| ä                   | permit. Departr Imports any Injv   |                      | boloph   | L. KUM   | Joseph L. Rus   | s Funere                                   | il Home f                      | ), A ,                             |
| П                   |  |                      | 23a. Part / Enter the disease, or com  | plications that caused the death. Do no                          | ot enter the mode of dying, such as cardia                              | c or respiratory arrest,                   |                                | Approximate                        |
|                     | Physician  |                      | Immediate Cause (Final   | ATA C  |   |  | į č                            | nterval Between<br>Onset and Death |
| 1                   | /Medical   |                      | disease or condition resulting in death)   | a. Due to (or as a consequence of                                | '):   |  |                                |                                    |
| ı                   | Examiner   |                      |  | b  |   |  |                                |                                    |
| ×                   | 7 -  | ner                  | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying | Due to (or as a consequence of                                   | ):  |  |                                |                                    |
|                     | cuted  | Examiner             | cause. Enter Underlying Cause (Disease or injury that initiated events             | C  |   |  |                                |                                    |
| 760,                | be executed<br>ician end<br>burial-transit   |                      | resulting in death) Last   | Due to (or as a consequence of                                   | ):  |  |                                |                                    |
| 876                 | e y e  | licai                |  | d  |   |  |                                |                                    |
| 89 x                | ertific<br>ling p  | Physician/Medi       | IF FEMALE:   | 00-14  |   |  |                                |                                    |
| Вох                 | ath c<br>attenc  | lan/                 | 23b. Was decedent pregnant in the past 12 months?                                  | 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetel death | 3 ☐ Ectopic pregnancy   |  | 23d. Date of delivery  Month D | /<br>⊎ay Year                      |
| o.                  | at the de<br>by the a  | ysic                 | 1 ☐ Yes 2 ☐ No<br>9 ☐ Unknown  | 4□Pregnant at time of death<br>9□Unknown                         | 5 Other (specify)   |  |                                |                                    |
| <u>α</u>            | that the post of t |                      | Part II. Other significant conditions of   | ontributing to death but not resulting in                        | the underlying cause given in Part I.                                   | 23e. Did tobaco                            | o use contribute to the        | cause of death?                    |
| ds,                 | 8 50   | d by                 |  |  |   | 1 ☐ Yes                                    | 2 □No 3 □ Probab               | oiy 4 Unknown                      |
| Record              | w requir<br>been si<br>should l  | Completed            |  |  |   | 24a, Was an                                | 24h Ware autons                | y findings available               |
| Be                  | The lay  | m                    |  |  |   | autopsy<br>performed                       | ? prior to comp<br>death?      | oletion of cause of                |
|                     |  |                      | 25. Was case referred to medical   |  | 00 81   | 1 Yes 2                                    | No 1 □ Yes 2                   | DAG                                |
| Vital               | Physician:<br>this certific<br>ral director,   | o Be                 | examiner?  | Hospital: 1 ☐ Inpatient 2 ☐ ER/Outp                              | Other   | ath (Check only one)<br>Iome 5 Residence   | 6 Other (Specific              |                                    |
| o                   | g Phy<br>er this<br>eral d   | <b>-</b>             | 27. Manuer of Death  | 28a. Date of Injury 28b. Til                                     | me of 28c. Injury at  | 28d. Describe how in                       |                                |                                    |
| <b>Jivision</b>     | or Attending Ph<br>ifter death.<br>Director: After th<br>in by the funeral   | rtification;         | 1 ✓ Natural 5 ☐ Pending<br>2 ☐ Accident investigation                              |  | ury Work?<br>M 1 ☐ Yes 2 ☐ No   |  |                                |                                    |
| Vis                 | er der<br>ecto<br>by th  | tifica               | 3 Suicide 6 Could not be determined  | 28e. Place of Injury - At home, farr<br>building, etc. (Specify) | n, street, factory, office  | 28f. Location (Street<br>City or Town, Str | and Number or Rural F          | Route Number,                      |
| $\overline{}$       | 0 # 10 E   | 듧                    |  | building, sto. (Specify)   |   | July of Form, Of                           | ,                              |                                    |

To the Hospital c within 24 hours af To the Funerel D completely filled in Medical Ce

1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one)

29b. Signature and title of certifier

29c. License number 057727

29d. Date signed (Month, Day, Year)
12 22 5

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

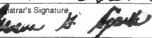
November 1 (Month, Day, Year)

DEC 2 3 2005

32. Relistrat's Signature

DEC 2 3 2005

State Registrar



|            |  |                  | For State Registrar   | State of M  |  | / Dep              |  | t of H                 | ealth a                      |                 | •                                  |                            | nn                    | 5                             | 415                                     | 06                   |
|------------|--|------------------|---|---|--|--------------------|--|------------------------|------------------------------|-----------------|------------------------------------|----------------------------|-----------------------|-------------------------------|---|----------------------|
|            | 8 × ×  |                  | Decedent's Name (First, Middle, I   | .ast)   |  |                    |  |                        |                              |                 | 2. Date of D                       | eath                       |                       |                               | 3. Time of                              | f Death              |
|            | Physicia<br>/Medic   |                  | WILLIAM H   | < FLE   | MINO   | Ā                  |  |                        |                              |                 | DE CEME                            | EK Day                     | 77 20                 | /ear<br>20(-                  | 14:5                                    | 14/Ms                |
| 1 3        | Examin   |                  | 4a. Facility Name (If not institution, g  |   |  |                    |  | _                      | Location of                  |                 |                                    | 4c.                        | County of             |                               |   |                      |
|            |  |                  | GOOD SAME   | MITAN   | Hospin   | AL                 |  |                        | TIM                          | -               |                                    |                            |                       |                               |   |                      |
| -          | Funeral Director   |                  | 212-34-4289   | . Sex 7. Ag   | ge (In yrs. last<br>76   | Yrs.               | If Under<br>Months   | 1 Year<br>Days         | If Under<br>Hours            | 24 Hrs.<br>Min. | 8. Date of B<br>(Month, D<br>16-6- | irth<br>Pay, Year)<br>- 29 | 1                     | Birthp<br>Cour<br>NC          | lace (State o                           | or Foreign           |
|            | and *  |                  | Usual Residence of Decedent  10a. State 10b. County   |   | 10c. City, T   | own or Le          | ocation  |                        | -                            |                 |                                    |                            |                       | 1                             | 0d. fnside C                            | ity Limits           |
|            | dany!  | ō                | MD  |   | Balt   | imor               | ce :   |                        |                              |                 |                                    |                            |                       |                               | 1X Yes                                  | 2 🗌 No               |
|            | the 1  | rect             | 10e. Street and Number  |   |  |                    | 10f. Zip   | Code                   |                              |                 |                                    | 10g. Citi                  | izen of Wh            | at Cour                       | itry?                                   |                      |
|            | 3a or  | Ö                | 1323 N. Montfo  | ord Ave.  |  |                    | 2  | 1213                   | 3                            |                 |                                    | U.S.                       | . A                   |                               |   |                      |
|            | death<br>ms 2  | Funeral Director | 11. Marital Status  | 12. Was Decedent  |  | 13.                | Was Deced  | lent of Hi             | spanic Ori                   | gin? (Spe       | ecify Yes or N<br>Rican, etc.)     | 0-                         | 14. Race -            |                               |   |                      |
| 9          | or Ite   | Ē                | 1 Never Married 2 Married   | Armed Forces's  1 Tyes 2 Till Yes, Give                                 |  |                    | 1 Yes, spec  |                        |                              | i, Puerto       | Hican, etc.)                       |                            | Specify: E            | White,                        |   |                      |
| 93         | ours<br>iral',   | d by             | 3 XWidowed 4 ☐ Divorced   | Year or Dates:  |  |                    | 10 163   | 21110                  | эрвопу.                      |                 |                                    |                            | эреспу. [             | этач                          | - N                                     |                      |
| 21215-0036 | within 72 hours atter death with the Maryland<br>ene.<br>then "neturel", or Items 23a or 28a-f show<br>the Marileal Exertainer must be notified at | Completed        | 15. Decedent's<br>(Specify only highest of  | Education<br>grade completed)   | 1  | 6a. Dece           | dent's Usua<br>kind of wo<br>DO NOT us   | al Occupa<br>rk done d | ition<br>(u <i>ring m</i> os | t of work       | ing                                | 16b. Ki                    | ind of Busi           | ness/Ind                      | dustry                                  |                      |
| 121        | withir<br>ne.<br>then  | E D              | Elementary/Secondary (0-12) 7th   | Coflege (1-4or  |  | _                  |  |                        |                              |                 |                                    | D 1 4                      | ا امد:                | г                             |   |                      |
|            | filed withi<br>Hygiene.<br>other ther  |                  | 17. Father's Name (First, Middle, La  | st)   | 1  | Macii              | ine  | oper                   |                              |                 | e (First, Middl                    |                            | ind]<br>Sumame)       |                               | us.                                     |                      |
| Maryland   | Mental<br>Mental<br>arked<br>atic ev   | To Be            | unknown   |   |  |                    |  |                        |                              |                 | rsey                               |                            |                       |                               |   |                      |
|            | alth and 27 is ma  |                  | 19a. Informant's Name/Relationship Ennest Fleming   |   |  |                    | -  |                        |                              |                 | al Route Num<br>7e. Ba             | -                          |                       |                               |   |                      |
| Baltimore, | Pages 1 a<br>nent of He<br>ant: If Item<br>ary or othe   |                  | 20a. Method of Disposition 1  ↑ Burial 2 ☐ Cremation 3  4 ☐ Donation 5 ☐ Other (Spe   |   | cem  | etery, cre<br>y Tr | osition (Nam<br>matory or o<br>init  | ther place<br>Y        | 1                            | 12-2            | 22-05                              | Dun                        | ocation - Ci<br>ndalk | , MI                          | )                                       |                      |
| Balti      | permit. Pages<br>Department of the Important: If Ite any injury or of once.  |                  | 21. Signature of Funeral Service Lic  | Marine  | /  | 2                  | 007  | East                   | ern                          | Ave             | sley<br>. Bal                      | to.                        |                       |                               |   |                      |
|            | Physician<br>/Medical<br>Examiner  | -                | 23a. Part 1. Enter the disease, or or shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, | a. Se   | S a consequen  | ice of):           |  |                        |                              |                 |                                    | arrest,                    |                       |                               | Approximat<br>Interval Bet<br>Onset and | ween                 |
| 760,       | eath certificate be executed<br>attending physician and<br>tor use as the burial-transit   | cal Examiner     | Sequentially list conditions, is any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last            | Due to (or as   | SPIR s a consequer s a consequer   | ice of):           | FA<br>REN  |                        |                              |                 |                                    |                            | _                     |                               |   |                      |
| 687        | ficate<br>physics the  |                  |   | d   |  |                    | -  |                        | -4755                        | -               | W.1-                               |                            |                       |                               | -                                       |                      |
| .O. Box    | The law requires thet the death certifical ate hes been signed by the attending phyage 2 should be detached for use as the                         | Physician/Med    | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown   | 23c. If yes, outcome<br>1 □ Live birth<br>4 □ Pregnant a<br>9 □ Unknown | 2 🗌 Fetal de   | ath 3[             | □Ectopic pr<br>□ Other (sp   |                        |                              |                 |                                    | 4                          | 23d. Date o<br>Month  |                               | ,                                       | Year                 |
| s, P       | res thet<br>igned b  |                  | Part II. Other significant condition:   | _   |  | ng in the t        | inderlying c   | ause give              | n in Part I                  |                 |                                    |                            | _                     |                               | e cause of o                            |                      |
| ord        | w require<br>been si<br>should I   | ted              | 1 DIABETES  |   | •  |                    |  |                        |                              |                 | 1                                  | Yes 2                      | <u>-</u> -√1₀ 3       | Prob                          | ably 4 □l                               | Jnknown              |
| Records,   | he law<br>hes b  | Completed by     | 2. GASTROT  |   | UBE.   |                    |  |                        |                              |                 | 24a. Wa<br>aut                     | s an<br>opsy<br>formed?_   | pric                  | ere auto<br>or to cor<br>ath? | psy findings<br>npletion of c           | available<br>ause of |
| a          | ysician: The is certiticate he director, page  | ပိ               | 3 HYPERT<br>25. Was case referred to medical  | 2NS/ON  |  | 2000               |  |                        | 22 01                        |                 |                                    | a⊒No                       | 10                    | ] Yes                         | 2 No                                    |                      |
| Vital      | Physician:<br>this certitic<br>ral director,   | 00               | examiner?   | Hospital:   | ient 2 FB  | /Outpatie          | nt 3 DC  | Othe                   | 200                          |                 | me 5□Re:                           |                            | 6 MOthar              | (Canali                       | a)                                      |                      |
| of         | ਦੂ <u>ਦ</u> ਛ  | 7: To            | 27. Manner of Death   | 28a. Date of Inj<br>(Month, Da  |  | 3b. Time o         |  | 8c. Injury             |                              |                 | 28d. Describe                      |                            |                       |                               | '/                                      |                      |
| ion        | Attending<br>r death.<br>ector: Atter<br>by the tunes  | atio             | 1 Patural 5 ☐ Pending 2 ☐ Accident investigat   |   | ay rear)   | Injury             | М  |                        | r<br>Yes 2 🗍                 | No              |                                    |                            |                       |                               |   |                      |
| Division   | r Attender death   | Certification:   | 3 ☐ Suicide 6 ☐ Could no<br>4 ☐ Homicide determine  | ad 286. Place of In   | njury - At home  | e, farm, st        | reet, factory  | , office               |                              |                 | 28f. Location<br>City or T         | (Street an                 | d Number              | or Rura                       | Route Num                               | iber,                |
| Ö          | rs aft<br>al Dli   | Cer              |   |   |  |                    |  |                        |                              |                 |                                    |                            |                       |                               |   |                      |
|            | To the Hospital or Attent within 24 hours after death To the Funeral Director: completely tilled in by the   | Medical          |   | Physician: To the best<br>(aminer: On the basis of<br>and manner s      | of examination   |                    |  |                        |                              |                 |                                    |                            |                       |                               |   | ;)                   |
|            | To th<br>To th<br>Comp   | M                | 29b. Signature and title o certifler  |   |  |                    |  | License                |                              |                 |                                    | 29d. Dat                   | te signed (           | Month,                        | Day, Year)                              |                      |
|            |  |                  |   | - DR MAG  | J NAI  | N4 C               | 00 I   | 000                    | 6:                           | 23              | 9                                  | Dece                       | MAG                   | R                             | 19,00                                   | 205                  |
| 4          | ,  |                  | 30. Name and address of person wi   | no completed cause of   | death (Item 2  | За) (Туре          | , Print)   | _                      | 7 6 6<br>TIM                 |                 | ,                                  |                            |                       |                               | 11                                      |                      |
| 0          |  |                  |   | RITAN   | tto spi  | _                  | -/1  | 300                    | TING                         | CNE             | <u>-</u>                           |                            |                       |                               | <u> </u>                                |                      |
|            | Sta<br>Registr   |                  | 31. Date filed (Month, Day, Year)   | 32. Regist  | tear's Signatur  | e<br>Ar            | Rose   | No. 10                 |                              |                 |                                    |                            |                       |                               |   |                      |
|            | , ilegisti   |                  | חדרט  | O CODY  | A Carlotte State of the State o | 150                | A STATE OF THE PARTY OF THE PAR | Merca                  |                              |                 |                                    |                            |                       |                               |   |                      |

|          |   |                   |   | ype or Print<br>State of Man   |                                  |  |   | -  | _  | le.  |
|----------|---|-------------------|---|--|----------------------------------|--|---|--|--|--|
|          |   |                   | 1 - State<br>Registrar  |  |                                  | rtificate of   |   |  | Reg. No. 0 0 (                           | 5 41507  |
|          | Physici   |                   | 1. Decedent's Name (First, Middle, Last)  Michael Marvin F1   | abortu   |                                  |  |   | 2. Date of Dea<br>Month                  | Day Y                                    | /ear 3. Time of Death  |
| ٠        | /Medio<br>Examin  |                   | 4a. Facility Name (If not institution, give si  |  |                                  | 4b. City, Town, o  | or Location of Death                            | Decemb                                   | 4c. County of                            | .00)   |
|          |   |                   |   |  | nter                             | femous - r   | more  |  | n/a                                      |  |
|          | Funeral<br>Director   |                   | 223-46-3026   |  | In yrs. last birthday)           | If Under 1 Year<br>Months Days                               | If Under 24 Hrs. Hours Min.                     | 8. Date of Birt<br>Month, Pay<br>June 30 | , Year 937                               | B. Birthplace (State or Foreign<br>Country)<br>Texas                       |
|          | death with the Maryland<br>ms 23a or 28e-f show   |                   | Usual Residence of Decedent  10a. State 10b. County   | 1  | Oc. City, Town or Lo             | ocation  |   |  |  | 10d. Inside City Limits 1 ☐ Yes 2 ☑ No                                     |
|          | ith the Marylar<br>or 28e-f show  | Director          | MD Baltimore  10e. Street and Number  |  | Arbutus                          | 10f. Zip Code  |   |  | 10g. Citizen of Wh                       |  |
|          | With<br>Ba or   |                   | 911 Stormont Circle   | 3  |                                  | 21227  |   |  | United St                                | •  |
|          | ms 23   | Funeral           |   | 2 Was Decedent Eve   | er in U.S. 13.                   | Was Decedent of h  | Hispanic Origin? (Spe                           | ecify Yes or No-                         | 14. Race -                               | American Indian,   |
| 0000     | or Ite  | by                | 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced  | Armed Forces? 7 1 New Yes 2 No. 1f Yes, Give / Year or Dates:        | 00 50                            | lf Yes, specify Cub<br>1 □ Yes 2 ☑ No                        | an, Mexican, Puerto                             | Rican, etc.)                             | Black,<br>Specify:                       | White, etc. White  |
| 0-0-1    | 2 should be filed within 72 hours after and Mental Hygiene. Is marked other then "nature!, or Ite wantic event, Ite Medical Examina   | Completed         | 15. Decedent's Educ<br>(Specify only highest grade<br>Elementary/Secondary (0-12)                           | ation<br>completed)<br>College (1-4or 5+)                            | (Give                            | dent's Usual Occup<br>kind of work done<br>DO NOT use retire | during most of working                          | ng                                       | 16b. Kind of Busi                        | ness/Industry  |
| 7        | giene<br>giene<br>er the  | Com               | 12  | College (1-401 5+)   | Busin                            | ness Owne  | r   |  | Shippi                                   | ng   |
| 2        | be file<br>tal Hy<br>d oth  | Be                | 17. Father's Name (First, Middle, Last)   |  |                                  |  | 18. Mother's Name                               | (First, Middle,                          | Maiden Sumame)                           |  |
| II y is  | s 1 and 2 should<br>f Health and Men<br>item 27 Is marke<br>other treumatic   | ٦<br>ر            | William Michael Fl. 19a. Informant's Name/Relationship (Typ   |  | Lucille I                        | Foster ral Route Number, City or Town, State, Zip Code)      |   |  |  |  |
| M        | and 2   |                   | Jody Flaherty / da  | ughter   |                                  | -  | am Way Wes                                      |  |  |  |
| ב<br>ס   | permit. Pages 1 ar<br>Department of Hea<br>Importent: If item<br>any injury or othe<br>once.  |                   | 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Re 1 ☐ Donation 5 ☐ Other (Specify)                 | emoval from State  |                                  | matory or other pla  | ce)   | )ate                                     | 20c. Location - Ci                       |  |
|          | mit. Poartme  |                   | 21. Signature of Funer Service License  |  | Bayview (                        | 2. Name and Addre  |   |  | uneral Ho                                | re, Maryland   |
|          | permi<br>Depa<br>Impo<br>any is<br>2000   |                   | 23a. Part1. Enter the disease, or complic shock, or heart failure. List only one Immediate Cause (Final     | cations that caused the cause on each line.                          |                                  |  | ur SPring                                       | Rd Arb                                   | utus, Maj                                | ryland 21227  Approximate Interval Between Onset and Death                 |
|          | /Medical<br>Examiner  |                   | disease or condition resulting in death)  | Due to (or as a c  | onsequence of):                  |  |   |  |  | 10 days  |
|          |   | iner              | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | Due to (or a a c   |                                  | art fail   | use   |  |  | _ Zylars   |
| 5        | executed<br>in and<br>rial-transit  | Examiner          | Cause (Disease or injury that initiated events resulting in death) Last                                     | Due to (or as a c  |                                  | o cuyo pr  | Huy   |  |  | Zylars   |
| 00/      | ite be<br>iysicia<br>ne bui   | icai              | d.  |  |                                  |  |   |  |  |  |
| 00       | artifica<br>ing ph<br>e as ti   | Med               | IF FEMALE:  |  |                                  |  |   |  |  |  |
| .O. DOX  | requires that the death certificate be e.<br>een signed by the attending physician<br>hould be detached for use as the buria          | Physician/Medical | 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown                                      | Sc. If yes, outcome of 1 Live birth 2 [ 4 Pregnant at time 9 Unknown | Felal death 3                    | Ectopic pregnanc<br>Other (specify)                          | y   |  | 23d. Date of Month                       | ,  |
| cords, r | w requires that the de<br>been signed by the<br>should be detached  | þ                 | Part II. Other significant conditions cont Drabetes Mellit  | tributing to death but r   | not resulting in the u           | nderlying cause gr   | ven in Part I.                                  |  |  | ute Io the cause of death?   |
| ב        | slcien: The law re<br>certificate has bee<br>irector, page 2 sho  | ompleted          | Hypotension   |  |                                  |  |   | 24a. Was a autop perfor                  | megal? ∣ dea                             | ore autopsy findings available or to completion of cause of ath?  Yes 2 No |
| N I G    |   | BeC               | 25. Was case referred to medical  |  |                                  |  | 26. Place of Death                              |  |  | 7163 25410   |
| 5        | > .9 0  | ToE               | examiner?   | ospital: 1 Inpatient   | 2 ER/Outpatier                   | nt 3□ DOA Oth  | ner: 4 Nursing Hon                              | ne 5□Resid                               | lence 6 Other                            | (Specify)  |
| JIVISION | Attending Ph<br>ir death.<br>ector: After th<br>by the funeral  | ation:            | 27. Manner of Death  1 Natural 5 Pending 2 Accident investigation   | 28a. Date of Injury<br>(Month, Day Y                                 | (ear) 28b. Time o                | Wo   | ryat 2<br>rk?<br> Yes 2 ∐No                     | 28d. Describe h                          | ow injury occurred                       |  |
| <u> </u> | el or Atte<br>s after de<br>il Directo<br>d in by th  | Certification:    | 3 ☐ Suicide 6 ☐ Could not be determined   | 28e. Place of Injury<br>building, etc. (                             | - At home, farm, sti<br>Specify) | reet, factory, office  | 2   | 28f. Location (S<br>City or Tow          |  | or Rural Route Number,   |
|          | To the Hospitel or Attending f<br>within 24 hours after death.<br>To the Funerel Director: After<br>completely filled in by the funer | edicai C          | 29a. Certifier 1 Certifying Physi (Check only one) 2 Medical Examin   | ician: To the best of re: On the basis of exand manner stated        | ramination and/or in             | h occurred at the til<br>vestigation, in my o                | me, date and place, a<br>opinion, death occurre | and due to the co                        | cause(s) and mann<br>date and place, and | er as stated. If due to the cause(s)                                       |
| ,        | To the within To the comple   | Me                | 29b. Signature and little of certifier  |  |                                  | 29c. Licens  | e number  |  | 29d. Date signed (                       |  |
|          | 1411  |                   | 30. Name and address of person who cor  |  | h (Item 23a) (Type,              | Print)   | φισ   | 1  | secember                                 | 20, 2005   |
|          | 10,   |                   | To Change IF  | chase stre   | et #311                          | 8.11   |   |  |  |  |

State Registrar DHMH 17 Rev 1/2001 Baltimore.

To Chang [E. Chose Streck # 31. Date filed (Month) Day, Year) 32. Registrar's Signature DEC 2 3 2005

DEXTER GARLAND Amend item#20b,perFH,G851,1-3-06 TT

Amend item#8,20c,perFh,G850,12/23/02 III 5-08393 RKD State of Manyland & Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death DECEMBER 12, **Physician** Dexter Costella Garland 2005 2:42P. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner BALTIMORE 2617 E, PRESTON STREET N/A| Months | Days | Hours | Min. | 8. Date of Birth (Month, Day, Year) | 043 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** M☐M 2☐F Yrs. 053-36-9080 Director 62 7,20 Maryland Dec Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f ehow the Medical Examiner must be notified at 1 ¥ Yes 2 □ No Baltimore Be Completed by Funeral Director N/AMaryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2617 E. Preston Iteme 23a Street 21213 USA 12. Was Decedent Ever in U.S.
Armed Forces?
1 ⊠Yes 2□No Viet
MYes, Give
Year or Dates: Nam Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Maryland 21215-0036 ò 1 ☐ Yes 2 No Specify: Specif Black 3 Widowed 4 ☐ Divorced 'naturel' 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry other than Elementary/Secondary (0-12) College (1-4or 5+) Private Company Security 12th grade ps 1 and 2 should be filed of Health and Mental Hygie of Health and Talmarked other or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be Department of Health and Mental Important: If I lem 27 Is marked 4 eny lighty or other traumatic even soige. Willie S. Garland Lucy Carrington 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3940 Chesterfield Avenue Baltimore Maryland
ce of Disposition (Name of place) 12/12/05 20c. Location - City pt Town, State
MILIS Henry W. Garland/Brother Baltimore, 20b. Place of Disposition (Name of 20a. Method of Disposition Garrison Forest Burial 2 ☐ Cremation 3 ☐ Removal from State Vet. Owings Misss, Md 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Juneral Service Licensee 22. Name and Address of Facility Chatman-Harris Funeral Home 5240 Reisterstown Rd Baltimore, Md 21215 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, effect, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician CARDIOVASCULAR DISEATER ATMERISCLERATIC /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of). Attending Physician: The law requires that the deeth certificate be executed for use as the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ONIC COHULISM 2 VINO 3 Probably 4 Unknown 1 Tes 24a. Was an autopsy performe 24b. Were autopsy lindings available prior to completion of cause of death?

1 ✓ res 2 □ No 190Yes 2 🗆 No Director: After this certific in by the funeral director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) SCENE ဥ 1X Yes 2 □ No 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death Cerlification: 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, lactory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide # E pelli 24 hours Medical 29a Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) within 2 and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. DECEMBER 13, 2005 completed cause of death (Item 23a) (Type, Print) POUS As 4-111 PENN STREET BALTIMORE MARYLAND 21201 ms 31. Date liled (Month, Day, Year) 32. Regisfrar's Signature State 3 2005 Registrar

|   | 1              | State of Maryland / Dep  | eartment of Health and Nertificate of Death  | Mental Hygie  | -  | 41509  |
|---|----------------|--|--|---|--|--|
| Physiciar   |                | 1. Decedent's Name (First, Middle, Last)  Laurence Edward Harrison   |  | 2. Date of Death<br>Month                                   | Day Year   | 3. Time of Death                                 |
| /Medica<br>Examine  | 1              | 4a. Facility Name (If not institution, give street and number)   | 4b. City, Town, or Location of Death   | Dec.11,2  | 4c. County of Death  | 1347   |
| LXdiffille  |                | Sinai Hospital   | Baltimore  |   | N/A  |  |
| Funeral<br>Director   |                | 5. Social Security Number  6. Sex 7. Age (In yrs. last birthda)  244-42-3308  Usual Residence of Decedent  | Months   Days   Hours   Min.   | 8. Date of Birth<br>(Month, Day, Y                          | 9 Birth<br>Cou<br>935 N. Ca                                  | place (State or Foreign<br>intry)<br>arolina     |
| Maryland  | -              | 10a. State 10b. County 10c. City, Town or I  | ocation<br>Limore  |   |  | 10d. Inside City Limits 1   Yes 2 □ No           |
| ifter death with the Mar<br>rifteme 23a or 28a-fel<br>niner must be notified  | 20 0           | 10e. Street and Number #400<br>3737 Clarks Lane  | 10f. Zip Code<br>21 21 5   | 10g   | . Citizen of What Cou<br>USA                                 | intry?   |
| 1215-0036 within 72 hours after death with the Maryland ene. than "naturel", or Iteme 23s or 28s-1 show he Marical Exeminer must be notified at                             | 2              | 11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 Yes, Sive Year or Dates:   | Was Decedent of Hispanic Origin? (S<br>If Yes, specify Cuban, Mexican, Puerto<br>1 ☐ Yes ※ No Specify:   | pecify Yes or No-<br>o Rican, etc.)                         | 14. Race - Amer<br>Black, White<br>Specify: Bla              | , etc.   |
| Maryland 21215-0036 d 2 should be filed within 72 hours at th and Mental Hygiene. 77 is marked other than "naturel", or traumatic event, the Macifial Exami                 | Completed      | (Specify only highest grade completed) (Giv  | edent's Usual Occupation<br>e kind of work done during most of wor<br>DO NOT use retired)<br>DOI Teacher | Ba  | b. Kind of Business/laltimore ablic Sch                      | City   |
| aryland 2<br>should be filed<br>and Mental Hygis<br>marked other<br>umatic event, II  | o pe o         | 17. Father's Name (First, Middle, Last) Unk •  |  | ne (First, Middle, Ma<br>s Thomps                           |  |  |
| Itimore,<br>it. Pages 1 an<br>intment of Heal<br>intent: If Item 2<br>injury or other   |                | Edith Harrison/Wife 373  20a. Method of Disposition  1  Burial 2  Cremation 3  Removal from State 4  Donation 5  Other (Specify) Greenmo   | unt Cemetery  22. Name and Address of Facili©ha  | Baltimor<br>Date 20<br>1/19/05 Ba                           | e Maryla<br>c Location - City or 1<br>altimore,<br>cris Fune | ond 21215<br>own, State<br>Maryland<br>eral Home |
| Derm<br>Depa<br>Impo  |                |  | 240 Reisterstow  | n Rd Ba   | altimore   |  |
| 76(   | ical Exa       | disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of): | O JOSEPH   | DISEA   | SE   | Dys  |
| I Records, P.O. Box 68760,  The law requires that the death certificate be exite has been signed by the attending physician page 2 should be detached for use as the burian | -              | in the past 12 months?   | □Ectopic pregnancy □ Other (specify)   |   | 23d. Date of delik   | very<br>Day Year                                 |
| opuires that en signed bould be detailed  | 20             | Part II. Other significant conditions contributing to death but not resulting in the   | underlying cause given in Part I.  | 23e. Did toba<br>1 ☐ Yes                                    | cco use contribute to  | the cause of death?                              |
| 0 8 8 0   | Completed      |  |  | 24a. Was an<br>autopsy<br>performe<br>1 \( \text{Yes} \) 25 | prior to c<br>death?   | opsy findings available ompletion of cause of    |
| of Vital F Physicien: Th rthis certificate ral director, pag  | 0              | 25. Was case referred to medical examiner?  1 □ Yes 2 No  Hospital: 1 □ Inpatient 2 ▼ FV/Outpati   | Othor  | ath <i>Check onli ve)</i><br>Iome 5□ Residen                | ce 6 ☐Other (Spec  | n(h)   |
| Division of a or attending Physical or attendenth: After this birector: After this in by the funeral director.  | ation:         | 27. Mapner of □ ath 1 Natural 5 □ Pending 2 □ Accident   28a. Date of Injury (Month, Day Ye 1) 28b. Time Injury  | of 28c. Injury at  | 28d. Describe how   |  | .,,,   |
| Divis   | Certification: | 3 Suicide 6 Could not be determined 28e. Place of Injury : At home, farm, building, etc. (Specify)   |  | City or Town,   |  |  |
| he Hospi<br>n 24 hou<br>he Funer<br>pletely fill  | edical         | 29a. Certifier  (Check only one)  Cartifying Physician: To the best of my knowledge, de Medical Examiner: On the basis of examination and/or and manner stated.  | investigation, in my opinion, death occu   | irred at the time, date                                     | se(s) and manner as and place, and due                       | to the cause(s)                                  |
|   |                | 29b. Signature and address of person who completed lause of death (Item 23a) (Typ  | 29c. License number  29c. Print)   | 1   | 2/15/6   | 05   |
| 3   |                | 31. Date filed (Month, Day, Year)  32. Registrar's Signature   | flo N. CHARCE  | SSB   | ALTMON   | 5,M21218   |
| State<br>Registra   |                | DEC 2 3 2005   | Low .  |   |  |  |

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 2. Dete of Death 1. Decedent's Name (First, Middle, Last) Day Physician 20, 2005 6:30PM DEC. FRANK L. HARGRAVE /Medical 4b. City, Town, or Location of Death 4c. County of Deeth 4e Fecility Neme (If not institution, give street end number) Examiner GENESIS-HAMILTON CENTER BALTIMORE If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 08/13/1925 5. Social Security Number 7. Age (In yrs. last birthdey) **Funeral** Days Hours 1√2 M 2□ F 80 Yrs. 240-20-2177 N. CAROLINA Director Usual Residence of Decedent permit. Peges 1 and 2 should be filed within 72 hours after death with the Manyland Depertment of Haalth and Mentel Hygiene. Important: if item 27 is marked other than "natural", or items 23e or 28a-f show eny injury or other traumatic event, the Medical Eventment must be continued. 10d. Inside City Limits 10a Stete 10c. City, Town or Location X□Yes 2□No BALTIMORE CITY MD N/ADirector 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number USA 21214 6040 HARFORD ROAD 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Merried 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: BLACK þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) MARYLAND DRY DOCK Elementary/Secondery (0-12) College (1-4or 5+) CORPORATION 12TH 17. Fether's Name (First, Middle, Lest) 18. Mother's Name (First, Middle, Maiden Sumame) JANNETTE PARTEE FRANK L. HARGRAVE, SR. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 5000 LINDSAY ROAD, BALTIMORE, MD 21229 FRANCINE HARGRAVE/DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State WESTERN STAR CEMETERY 12/29/05 CATONSVILLE, MI 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility HOWELL FUNERAL HOME 21207 21. Signature Puneral Service Licensee 4600 LIBERTY HEIGHTS AVE, BALTIMORE, MD Enter the disease, or complications that caused the dead or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death n. Do not enter the mode of dying, such as cardiac or respiratory arrest, Physician Immediate Cause (Final disease or condition resulting in death) /Medical PHARYNGEAL CANCER Examina Due to (or as a consequence of): Examiner ettending physicien and for use es the burial-trensit The lew requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence on Division of Vital Records, P.O. Box 68760, by Physician/Medical Due to (or as a consequence of): Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed 1 Yes 2 12 No 1 ☐ Yes 2 ☐ No Attending Physician: Be 25. Wes case referred to medical examiner? 26. Piece of Death (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To To the Hospital or Attending Physi within 24 hours efter death.

To the Funeral Director: After this completely filled in by the funerel dii After this 28e. Date of Injury (Month, Dey Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury et Work? 1 Naturel 5 Pending 1 🗌 Yes investigation 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 3 ☐ Suicide 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as steted.

2 Medicat Examiner: On the basis of exemination end/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only 29d. Date signed (Month, Dey, Year) 29c. License number 29b. Signature and title of certifier amarisans M. D D16619 30. Name and eddress of person who completed ceuse of deeth (Item 23e) (Type, Print) HARFORD RD. BALTIMORE, MD. 21234 L.VERGARA-SOARES 6040 31. Date filed (Month, Day, Xear) 32 Registrer's Signature State Sale and Registrar

**DHMH 16 Rev 6/95** 

**ORIGINAL** 

|   |              |                | Please I   | -   |                     |                       |                            | of Health ar  |             | •                                      | _                  | Jie.                                   |  |
|---|--------------|----------------|--|---|---------------------|-----------------------|----------------------------|---|-------------|--|--------------------|--|--|
|   |              | 1              | For Stete  | State of Ma                                     | arylano             |                       |                            | t of Health ar<br>e <i>of Death</i>                   | iu ivie     |  | . N2 0 0           | 5 1                                    | 511                                    |
| 3 Jan 1   |              | 1              | Registrar  1. Decedent's Name (First, Middle, Last)                        |   |                     | 001                   | imoute                     | Orbeatti  | 2           | Date of Death                          |                    | 3. T                                   | ime of Death                           |
| Phys  |              | ı,             | LESTER C. HUD  |   | ₹.                  |                       |                            |   | Г           | Month<br>DEC. 1                        | 9, 200             | Year<br>5 1:                           | 05A M                                  |
|   | dica<br>nine |                | a. Facility Name (If not institution, give                                 | street and number)                              |                     |                       | 4b. City,                  | Town, or Location of I                                | Death       |  | 4c. County         |  |  |
| Production of the state of the | j - A        | 1              | STELLA MARIS D   |   |                     |                       |                            | OWSON   | 4 Hrs. La   |  |                    | TIMORE                                 |  |
| Funer   |              |                | Social Security Number 6. Sec  | 7. Ag   | 9 (In yrs. Ia<br>86 | st birthday)<br>Yrs.  | Months                     | 1 Year If Under 24<br>Days Hours                      | Min. 8      | Date of Birth<br>(Month, Day,<br>12/16 | Year)<br>/ 1 9 1 9 | 9. Birthplace (S<br>Country)<br>VIRGIN | State or Foreign                       |
| Direct  | or           |                | 215-14-0825 X- Usual Residence of Decedent                                 |   |                     |                       | l                          |   |             | 12/10                                  | 1313               | VIRGIL                                 | 1 1 2 2                                |
| ryland  | 1            |                | 10a. State 10b. County MD N/A  |   | 10c. City,          | Town or Lo            |                            | RE CITY   |             |  |                    |  | ide City Limits<br>☐Yes 2 ☐ No         |
| Ba-fs   | Dispetor     | 2              |  |   |                     | DAL                   |                            |   |             | 100                                    | g. Citizen of V    |  |  |
| Fey, INIGITY IGITION AT A TONO SO.  I and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. If the art is marked other than "naturel; or items 23e or 28e-f show ther reumatic event, the Maritial Extering count is continued.  | Ċ            |                | 10e. Street and Number<br>1535 N. PULASK                                   | I STREET  |                     |                       | 10f. Zip                   | 21217   |             |  | USA                | Vital Country !                        |  |
| death   | 1000         | <u> </u>       | 11. Marital Status   | 12. Was Decedent                                | Ever in U.S         | 3. 13.                | Was Deced                  | ent of Hispanic Origin<br>of Cuban, Mexican, I        | n? (Speci   | fy Yes or No-                          |                    | e - American Ind                       | ian,                                   |
| after<br>or its   |              |                | 1 Never Married 2 Married  | Armed Forces? 1 X Yes 2 □ If Yes, Give          | տրդ.<br>ՄԸ          | ООД.                  | 1 ☐ Yes                    |   | ruello rii  | Dan, etc.)                             | Specify            | k, White, etc.                         |  |
| hours<br>urei',   |              | 2              | 3 Widowed 4 Divorced   | Year or Dates:                                  | _ARM                | IY                    |                            |   |             |  |                    | BLACK                                  |  |
| in 72   | 1            | Completed      | 15. Decedent's Edu<br>(Specify only highest grad                           | e completed)                                    |                     | (Give                 | kind of woi<br>DO NOT us   | il Occupation<br>rk done during most o<br>se retired) | of working  | ' '                                    | ob. Kind of Bo     | sinessmoustry                          |  |
| J within<br>jiene.<br>r than "  |              | 5              | Elementary/Secondary (0-12) 12TH   | 5 YEARS   |                     | SCH                   | OOL                        | PRINCIPA  | L           |  | EDUCA              | TION                                   |  |
| al Hyg  |              | מפ             | 17. Father's Name (First, Middle, Last)                                    |   |                     |                       |                            |   |             | First, Middle, N                       | laiden Sumam       | (8)                                    |  |
| should be<br>nd Menta<br>marked   | 1            | 2              | JOHN H. HUDGI  |   |                     |                       |                            |   |             | WHITE                                  |                    |  |  |
| Mar<br>d 2 sh<br>th and<br>7 is rr<br>treur   |              | - 1            | 19a. Informant's Name/Relationship (Ty<br>MARGARET J. HUD                  |   | VIFE                |                       |                            | (Street and Number PULASKI                            |             |  |                    |  |  |
| s 1 and<br>f Health<br>item 27<br>other tr  |              | -              | 20a. Method of Disposition   |   | 20b. Pla            | ace of Dispo          | sition (Nan                | ne of   | Dat         |  |                    | City or Town, Si                       |  |
| nit. Pages<br>ertment of<br>ortent: If it   |              |                | 1 Burial 2 ☐ Cremation 3 ☐ F<br>4 ☐ Donation 5 ☐ Other (Specify)           | Removal from State                              | MD.                 | VET                   | ERAN                       | S CEM.  | 2/29        | /05                                    | OWINGS             | MILLS                                  | , MD                                   |
| 10 F 0 0 >  | once.        | 1              | 21. Signature of Funeral Service Licens                                    | e X   | 7                   | 22                    | 2. Name an                 | d Address of Facility                                 |             |  | JNERAI             | HOME                                   | 21207                                  |
| 0 88E5  | а            | 1              | 1/ /why  | 10 N  | tull                | 4                     | 600                        | LIBERTY   | HEIC        | HTS A                                  | /E., E             |  |  |
|   | N.           |                | 23a Agrit. Enter the disease, or completions, or hear failure. List only o | ications that caused<br>ne cause on each ti     | the death.<br>ne.   | . Do not ent          | er the mod                 | e of dying, such as ca                                | ardiac or i | respiratory arre                       | st,                | Inten                                  | oximate<br>val Between<br>et and Death |
| Physicia<br>/Medic  |              |                | Immediate Cause (Final disease or condition resulting in death)            | SEPSIS  |                     |                       |                            |   |             |  |                    |  |  |
| Examin  | _            |                |  | Due to (or as                                   | a consequ           | ence of):             |                            |   |             |  |                    |  |  |
|   |              | ie.            | Sequentially list conditions, if any, leading to immediate                 | Due to (or as                                   | a consequ           | ence of):             |                            |   |             |  |                    |  |  |
| executed<br>executed<br>en and<br>rial-transit  |              | Examin         | cause. Enter Underlying Cause (Disease or injury that initiated events     | c   |                     |                       |                            |   |             |  |                    |  |  |
| (bu,  |              | alEx           | resulting in death) Last   | Due to (or as                                   | a consequ           | ence of):             |                            |   |             |  |                    |  |  |
| oo/<br>ificate t<br>g physical  |              | ealcs          |  | d   |                     |                       |                            |   |             |  |                    |  |  |
| X Cent  |              | L/IME          | IF FEMALE:<br>23b. Was decedent pregnant                                   | 23c. If yes, outcome                            | of pregnar          | ncy                   | 3e . ·                     |   |             |  | 23d. Da            | te of delivery                         |  |
| death death e etter   |              | Physician/m    | in the past 12 months?<br>1 ☐ Yes 2 ☐ No                                   | 1 ☐ Live birth<br>4 ☐ Pregnant a<br>9 ☐ Unknown |                     |                       | ∃Ectopic pr<br>∃ Other (sp |   |             |  | Mo                 | nth Day                                | Year                                   |
| IS, F.C. I<br>res that the de<br>signed by the e  |              | ٢              | 9 Unknown  |   |                     | Nine in the co        |                            | - Park  |             | 320 Did toh                            | 2000 1100 0000     | ribute to the cau                      | en of death?                           |
| JS,<br>ires th<br>signed<br>I be d  |              | à              | Part II. Other significant conditions co                                   | ntributing to death t                           | out not resu        | iting in the u        | noerlying c                | ause given in Part I.                                 |             |  |                    | 3 ☐ Probably                           |  |
| ecords,<br>law requires<br>as been signi  |              | Completed      |  |   |                     |                       |                            |   | _           | 24a. Was ar                            |                    | Were autopsy fir                       |  |
| الم م ح الم   |              | Ē.             |  |   |                     |                       |                            |   |             | autops<br>perforn                      | red?               | prior to completion<br>death?          | on of cause of                         |
| VITAL H itclen: The certificete h rector, page  | - 1          | a l            | 25. Was case referred to medical   |   |                     |                       | 1                          | 26. Place of  | of Death (  | 1 ☐ Yes 2<br>Check only one            |                    | I□Yes 2□N                              | 10                                     |
| 0)  |              | 0              | examiner?<br>1 ☐ Yes 2 【 <b>X</b> No                                       | Hospital:                                       | ent 2 E             | ER/Outpatie           | nt 3 🗆 🗅                   | OA Other: 4 Nurs                                      | sing Home   | e 5 ☐ Reside                           | nce 6 X Oth        | er (Specify) <b>H</b>                  | OSPICE                                 |
| _ = = 0   |              |                | 27. Manner of Death  1X Natural 5 Pending                                  | 28a. Date of Inju<br>(Month, Da                 | y Year)             | 28b. Time o<br>Injury |                            | 28c. Injury at<br>Work?                               |             | ld. Describe ho                        | w injury occur     | red                                    |  |
| Dat Dat   |              | Cat            | 2 Accident investigation 3 Suicide 6 Could not be                          | 28e. Place of In                                | iury - At hou       | me farm et            | M reet factor              | 1 Tes 2 N   |             | If Location (St                        | eet and Numb       | er or Rural Rou                        | te Number.                             |
| DIVISION i or Attending after death. Director: Afte   |              | Certification: | 4  Homicide determined   | building, e                                     | c. (Specify         | )                     | reet, ractor               | y, onice  | -           | City or Town                           |                    | 0, 0, 1,0,0, 1,00                      |  |
| To the Hospitel or Att. within 24 hours atter det To the Funerel Direct   |              |                | 29a. Certifying Phy  | sicien: To the best                             | of my know          | wiedge, deat          | h occurred                 | at the time, date and                                 | place, an   | d due to the ca                        | use(s) and ma      | inner as stated.                       |  |
| the Ho<br>in 24<br>the Fu   |              | edical         | one)   | and manner st                                   |                     | ion and/or in         |                            | , in my opinion, death                                | n occurred  |  |                    |  |  |
| vith To 1   |              | Σ              | 29b. Signature and title of certifier                                      |   |                     |                       | 290                        | c. License number                                     |             | 25                                     |                    | d (Month, Day, )                       | rear)                                  |
| •   |              | -              |  | / ^-  | d db - 41:          | 00-) 7                | D-:1)                      | 172   | -)          |  | 101                | 19/05                                  |  |
| 4   |              |                | 30. Name and address of person who co  DR. TARTO MAHMOOI                   |   |                     |                       |                            | ). <b>TTM</b> ONTI                                    | IIM N       | Ф 2109:                                | 3                  |  |  |
| -   | Stat         | е              | 31. Date filed (Month, Day, Year)  | 22 Domint                                       | rar's Signat        | ura.                  |                            |   | CITO L      | <u> </u>                               |                    |  |  |
| Reg   | jistra       | r              | DEC 2 3  | 2005  | The Contract        | A. A.                 | pods                       | 2   |             |  |                    |  |  |

DHMH 17 Rev 1/2001

1:05 a.m.

**DECEMBER 19, 2005** 

LESTER HUDGINS

|  |                   | -              | - State<br>Registrer  | State of Marylan   |   | ent of Realth and ate of Death  |   | iene<br>No. 0 0 5                                   | 41512                                       |
|--|-------------------|----------------|---|--|---|---|---|---|---|
|  | ysicia            | _              | 1. Decedent's Name (First, Middle, Last)  | lmes   |   |   | 2. Date of Deat<br>Month<br>DECEMBE           | Day Year  | 3. Time of Death                            |
|  | Aedic.<br>amino   |                | 4a. Facility Name (If not institution, give st  |  | 4b. Ci  | ty, Town, or Location of Dear   |   | 4c. County of Death                                 | 1400 1                                      |
|  |                   |                | 1100 BOLTON STREET  |  |   | TIMORE CITY   | ,   | NA  |   |
| Fun<br>Dire  |                   |                | 5. Social Security Number 6. Sex 217-52-523 1 Usual Residence of Decedent                                   | 7. Age (In yrs. 55   | Yrs. Month  | der 1 Year If Under 24 Hrs<br>as Days Hours Min                       |   | 7,1950 No   | place (State or Foreign<br>ntry)            |
| /land  | 7                 | ŀ              | 10a. State 10b. County  | 10c. Cit   | y, Town or Location                               |   |   |   | 10d. Inside City Limits                     |
| Man,   | 2                 | ţċ             | Maryland N/A  | P  | Baltimo   | re-   |   |   | 1⊠Yes 2□No                                  |
| ith the  | 9                 | Directo        | 10e. Street and Number  | A 1 # 1  |   | Zip Code  | 1   | 0g. Citizen of What Cou                             | ntry?                                       |
| eth w  | Dast 2            | ral            | 1100 Bolton   | ST. 1316   |   | 21201   |   | USA   |   |
| 17215-0036 within 72 hours after deeth with the Maryland ene. then "neturel", or Items 23a or 28e-f ehow | Xacabar           | by Funeral     | 11. Marital Status  1 □ Never Married 2 ▼ Married  3 □ Widowed ◆ ▼ Broorced                                 | 2. Was Decedent Ever in U<br>Armed Forces?<br>1 ☐ Yes 2 No<br>If Yes, Give<br>Year or Dates: |   | cedent of Hispanic Origin? (5 pecify Cuban, Mexican, Puer No Specify: | Specify Yes or No-<br>to Rican, etc.)         | 14. Race - Ameri<br>Black, White,<br>Specify: D     |   |
| 15-0036<br>72 hours af<br>"neturel", or  | lical             | Completed      | 15. Decedent's Educ<br>(Specify only highest grade  | ation  | 16a. Decedent's U                                 | sual Occupation<br>work done during most of wo                        | nrkina  | 16b. Kind of Business/Ir                            | dustry                                      |
| Afthin Me  | a Ma              | mple.          | Elementary/Secondary (0-12)   | College (1-4or 5+)   | lite. DO NO                                       | use retired)  | , and   | 11 + 21   | Marilant                                    |
| N DO   | 별                 |                | 17. Father's Name (First, Middle, Last)   | \$   | L50010  | 18. Mother's Na   | me (First, Middle, M                          | Maiden Surname)                                     | marylana                                    |
| 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2  |                   | To Be          | Howard R.   | effin  |   | Mar   | agrat   | Tongs   |   |
| Maryland Id 2 should be file th and Mentel Hy To marked oth  | other treumatic   |                | 19a. Informant's Name/Relationship (Typ   | e. Print) (daughter)   | 19b. Mailing Addre                                | ess (Street and Number or R   | I Route Number                                | City or Town, State, Zip                            | Code) 20772                                 |
|  | er tre            |                | Mrs. Monique  | Taylor   | 13915   | Carlene D   | rive lu                                       | oper MaR  | boro, Md.                                   |
| 0 00 =   | =                 |                | 20a. Method of Disposition    1 □ Burial 2 ☑ Cremation 3 □ Re   |  | Place of Disposition (/<br>cemetery, crematory of | Name of prother place)  | Date  | 21c. Location - City or To                          | own, State                                  |
|  | <u>F</u>          |                | 4 □Donation 5 □ Other (Specify)  21. Sign up e of Funeral Serv ★ License                                    |  | eenMount  |   | 30/2005                                       | Balto. 1  | 1d.   |
| Deperminence   | eny inju          |                | 21. Sign trate of Funeral Service License   | P. Kun   | JoSep.  | and Address of Facility   | uneral  | Home, C.A.  |   |
|  |                   |                | 23a. Part V. Enter the disease, or complic  | ations that - sed the deat   | h. Do not enter the m                             |   | c or respiratory arre                         | to. Ma. 212   | Approximate                                 |
| Physic   | ian               |                | shock or heart failure. List only one<br>Immediate Cause (Final<br>disease or condition                     | List to the  | · Petter  | ochetic (   | ) sel 100                                     | 1 01  | Interval Between<br>Onset and Death         |
| /Med<br>Exami  | ical              |                | resulting in death)   | Due to (or as a conseq   | uence of):  | Co Debarce C  | T TOO DE                                      | aites on  | ,   |
| Exami  | Hel               | e.             | Sequentially list conditions, b.  | Due to (or as a conseq   | unana of  |   |   |   |   |
| D D  | nsit              | nine           | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | Due to (or as a conseq   | delice oi).                                       |   |   |   |   |
| O, exect   | rial-tra          | Examin         | that initiated events c. resulting in death) Last   | Due to (or as a conseq   | uence of):  |   |   |   |   |
| 68760, Criticate be executed physicien and   | he bu             | edicai         | d.  |  |   |   |   |   |   |
| × 62<br>entific  |                   | /Med           | IF FEMALE:  | a If you gutooms of season   |   |   |   |   |   |
| Box 6 eath certifications  | for us            | clan           | in the past 12 months?  | c. If yes, outcome of pregna<br>1 ☐ Live birth 2 ☐ Feta<br>4 ☐ Pregnant at time of d         | Ideath 3 ☐Ectopic                                 | pregnancy<br>(specify)  |   | 23d. Date of deliv<br>Month                         | ery<br>Day Year                             |
| P.O.<br>net the d<br>d by the  | ached             | Physician/M    | 1 ☐ Yes 2 ☐ No<br>9 ☐ Unknown   | 9□ Unknown   |   | (-2001))  |   |   |   |
|  | pe dei            | by P           | Part II. Other significant conditions cont  |  | ulting in the underlyin                           | g cause given in Part I.  |   | pacco use contribute to t                           |   |
| COrd:<br>v require<br>been sig   | pnoc              | Completed by   | Cerebrel Viscola  | Klinge   |   |   | 1 🗆 Ye  | es 2 No 3 Prol                                      | pably 4 AUnknown                            |
| e law  | 96 2 st           | mple           |   |  |   |   | 24a. Was a autops                             | y prior to co                                       | psy findings available mpletion of cause of |
| Vital Re   | or, pag           | မ C            | OF Man ages referred to madical   |  |   |   | perform<br>1 Yes 2                            | -   | 21/2 No                                     |
| Vit<br>/sicle<br>s certi   |                   | To Be          | 25. Was case referred to medical examiner?  1 ☑ Yes 2 ☐ No  | ospital:   | ER/Outpatient 3                                   | 04  | ath Check only on                             | e)<br>ence 6 MOther (Speci                          | COENTE                                      |
| VISION Of VITA Attending Physicien: or death. ector: After this certific                                 | ros .             |                | 27. Manner of Death   | 28a. Date of Injury<br>(Month, Day Year)   | 28b. Time of Injury                               | 28c. Injury at Work?  |   | w injury occurred                                   | MSCENE                                      |
| ISION<br>ttendir<br>death.<br>ctor: Af   | the funer         | atic           | ↑ Natural 5 Pending 2 Accident investigation  | (, 52) . 52)   | М   | 1 Yes 2 No  |   |   |   |
| 5 5 5  | led in by 1       | Certification: | 3 Suicide 6 Could not be 4 Homicide determined  | 28e. Place of Injury - At he building, etc. (Specif  | ome, farm, street, fact<br>y)                     | ory, office   | 28f. Location (St.<br>City or Town            | reet and Number or Rura<br>n, State)                | al Route Number,                            |
| Hosp<br>24 hou   | completely filled | edicai         | 29a. Certifier 1 Certifying Physical Check only one) 1 Certifying Physical Examin                           | cian: To the best of my known:  On the basis of examination and manner stated.               | wledge, death occurr<br>tion and/or investigati   | ed at the time, date and plaction, in my opinion, death occ           | e, and due to the ca<br>urred at the time, da | ause(s) and manner as s<br>ate and place, and due t | tated.<br>the cause(s)                      |
| To the   | сошь              | Me             | 29b. Signature and title of certifier   |  |   | 29c. License number   | 2   | 9d. Date signed (Month,                             | Day, Year)                                  |
| •  |                   |                | Theodore A  | 1. King a  | us  | OCME  | D   | ECEMBER 20,   | 2005  |
|  | $\eta$ .          |                | 30. Name and address of person who cor  |  |   |   |   |   |   |
|  | 8                 |                | 7 TE MURE MI, KIN   | 32. Registrar's Signa  |   | STREET, BALT  | IMORE, MA                                     | RYLAND, 212   | 01  |
| Po   | Sta               |                | DEC 2-3-2   | 005  | A 400   |   |   |   |   |

|  |                       | For<br>State<br>Registrar  | State of Mary  |   | rtificate of Death  | h  | Reg. Na 2005  | 4151   |
|--|-----------------------|--|--|---|---|--|---|--|
| Physici  | an                    | Decedent's Name (First, Middle,  | ROGER BA   | RNES HU   | NTER  | 2. Date of Dea<br>Month                              | Day Year  | 3. Time of Death                                   |
| /Medic   | cal                   | 4a. Facility Name (If not institution,   |  |   | 4b. City. Town, or Location   |  | 21, 2005<br>4c. County of Deat                            | 1:43 P   |
| Examin   | ıer                   | CARROLL HOSPI  |  |   | WESTMINS  |  | CARRO   |  |
| Funeral  |                       |  | 5. Sex 7. Age (/   | n yrs. last birthday)                             | If Under 1 Year If Under  | er 24 Hrs. 8. Date of Birt                           |   | hplace (State or Fore                              |
| Director   |                       | 217-07-5983 Usual Residence of Decedent  | 1 → M 2 □ F  | 85 Yrs.   | Months Days Hours   | Min. (Month, Da<br>6/24/1                            | 920 MAR   | RYLAND   |
| how  | _                     | 10a. State 10b. County   |  | Dc. City, Town or Lo                              |   |  |   | 10d. Inside City Lin                               |
| 89-fs  | cto                   | MD CARE  | ROLL   | NEW W   | INDSOR  |  |   | 1 ☐ Yes 2X   |
| Le a   | Dire                  | 10e. Street and Number   |  |   | 10f. Zip Code   |  | 10g. Citizen of What Co                                   | ountry?  |
| 18 23<br>1 mil   | era                   | 1423 HALLOWEI  | 12. Was Decedent Eve   | ar in IIS 13                                      | 21776   | Origin? /Specify Vos or No                           | USA<br>- 14. Race - Ame                                   | nican Indian                                       |
| points. Tages I and a stoom of the man and the man and the stoom with the man and the stoom of t | by Funeral Director   | 11. Marital Status  1 □ Never Married 2 ☑ Marrie 3 □ Widowed 4 □ Divorced  | Armed Forces?  |   | Was Decedent of Hispanic C<br>If Yes, specify Cuban, Mexic<br>1 ☐ Yes 🏖 No Specif |  | Black, White  | e, etc.  |
| n "natura<br>Medical E   | Completed by          | 15. Decedent's<br>(Specify only highest<br>Elementary/Secondary (0-12)   | s Education<br>grade completed)  College (1-4or 5+)  | 16a. Dece<br>(Give<br>life.                       | dent's Usual Occupation<br>kind of work done during mo<br>DO NOT use retired)     |  | 16b. Kind of Business/                                    | Industry   |
| Hygiene<br>thar tha  | Ę                     | 11   | College (1 40/ 3 F)  |   | CARPENTE  | ?  | CONSTRUC  | TION   |
| d othe   | BeC                   | 17. Father's Name (First, Middle, L  |  |   |   | her's Name (First, Middle,                           |   |  |
| Menti<br>arkad<br>atic e   | 2                     |  | HARRY  | HINGE   | ות דו   | ena i  | BARNES  |  |
| and Menta<br>is marked<br>reumetic e   |                       | 19a. Informant's Name/Relationshi  |  |   | ng Address (Street and Num  |  |   |  |
| ealth<br>m 27<br>har tr  |                       | BETTY H. HUNT  |  |   | HALLOWELL   |  |   |  |
| Department of Health Important: If Itam 27 any Injury or other tr once.  |                       | 20a: Method of Disposition<br>1 ☑ Burial 2 ☐ Cremation   |  |   | osition (Name of matory or other place)   | Date   | 20c. Location - City or                                   |  |
| tant:  |                       | 4 ☐ Donation 5 ☐ Other (Sp.  | ecity) ME  |   |   |  | WESTMINST   |  |
| Departimon many in proce.  |                       | 21. Signature of Fluderal Service L  | censee   | FO CO   | 2. Name and Address of Fac  |  |   |  |
| 10 E g ol  |                       | 23a. Part1. En er the disease, or c<br>shock, or head ailure. List o   |  |   | 54 E. MAIN  |  |   | D. 2115 Approximate Interval Between               |
| Medical personal pers | ıl Examiner           | disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | a. Due to (or as a c   | onsequence of):                                   | den Dise  | <i>G</i> 8 <b>©</b>                                  |   |  |
| ng physi   | Medical               | JF FEMALE:   | d  |   |   |  |   |  |
| ine raw requires may be be an extending phosp to be a stending phosp 2 should be detached for use as the   | Physician/Med         | 23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No 9 Unknown   | 23c. If yes, outcome of 1 Live birth 2 [ 4 Pregnant at tim 9 Unknown   | Fetal death 3                                     | Ectopic pregnancy Other (specify)   |  | 23d. Date of del<br>Month                                 | ivery<br>Day Year                                  |
| ned b  | y PI                  | Part II. Other significant condition   | s contributing to death but r  | not resulting in the u                            | nderlying cause giv <b>ê</b> n in Par   | t I. 23e. Did to                                     | obacco use contribute to                                  | the cause of death                                 |
| n sig  | d b                   | curric do  | structure 1  | Umana   | 25 Distase  | 101  | res 2 No 3 Pr   | obably 4 ∐Unkn                                     |
| s been si<br>should l  | Completed by          | curric do  | rial Ebre  | llahni  |   | 24a. Was   | an 24b. Were au   | topsy findings avail                               |
| ate has<br>page 2 s  | mo                    |  | , , ,  |   |   |  | rmed? death?  | completion of cause<br>2 \( \subseteq \text{No} \) |
|  | 0                     | 25. Was case referred to medical   |  |   | 26. Pla   | ce of Death (Check only o                            |   | 2 L NO   |
| tifica<br>tor. p   | To B                  | examiner?  | Hospital: 1 ☐ Inpatient  | 2 ER/Outpatie                                     | Other   | Nursing Home 5 Resid                                 |   | city)  |
| is certificate<br>director, pag  | 1 - 1                 |  | 28a. Date of Injury<br>(Month, Day Y   | (ear) 28b. Time of Injury                         | f 28c. Injury at Work?  | 28d. Describe h                                      | now injury occurred                                       |  |
| r this certifica   |                       | 27. Manner of Death  |  | ou.)  | M 1 ☐ Yes 2 [   | □No  |   |  |
| offer this certifications and director.  |                       | 27. Manner of Death  1  Matural  | ot be 28e. Place of Injury   | - At home, farm, st<br>Specify)                   | eet, factory, office  | 28f. Location (5<br>City or Tox                      | Street and Number or Ru<br>vn, State)                     | ıral Route Number,                                 |
| offer this certifications and director.  | Certification:        | 1  atural 2  Accident 3  Suicide 4  Homicide   | 28e. Place of Injury building, etc. (  | Specify)  ny knowledge, deal tamination and/or je | h occurred at the time, date a  | City or Toward and place, and due to the             | vn, State)  cause(s) and manner as                        | stated.  |
| offer this certifications and director.  | edical Certification; | 1  | 28e. Place of Injury building, etc. (  | Specify)  ny knowledge, deal tamination and/or je | h occurred at the time, date evestigation, in my opinion, de                      | and place, and due to the eath occurred at the time. | vn, State) cause(s) and manner as date and place, and due | stated. to the cause(s)                            |
| r this certifica   | Certification:        | 1  atural 2  Accident 3  Suicide 4  Homicide   | 28e. Place of Injury building, etc. (  | my knowledge, deal<br>amination and/or in         | h occurred at the time, date avestigation, in my opinion, do                      | and place, and due to the eath occurred at the time, | vn, State) cause(s) and manner as date and place, and due | stated. to the cause(s) h, Day, Year)              |
| offer this certifications and director.  | edical Certification; | 1  | 28e. Place of Injury building, etc. ( Physician: To the best of n xaminer: On the basis of exand manner stated | my knowledge, deal<br>amination and/or in         | h occurred at the time, date a vestigation, in my opinion, do 29c. License number | and place, and due to the eath occurred at the time, | vn, State) cause(s) and manner as date and place, and due | stated. to the cause(s) h, Day, Year)              |

|                     |  | -                 | State of Maryland / Dep  | eartment of Health and Mertificate of Death  |   | ne 005 41514  |
|---------------------|--|-------------------|--|--|---|---|
|                     |  |                   | 1. Decedent's Name (First, Middle, Last)   |  | 2. Date of Death<br>Month                       | Day Yeer 3. Time of Death   |
|                     | Physicia<br>/Medic   |                   | Richard Paul Hegarty   |  | December  |   |
|                     | Examin   |                   | 4a. Facility Name (If not institution, give street and number)   | 4b. City, Town, or Location of Death   | י   | 4c. County of Death   |
|                     |  |                   | 40 Iron Mill Garth   | Cockeysville   |   | Baltimore   |
|                     | Funeral<br>Director  |                   | 5. Social Security Number 6. Sex 7. Age (In yrs. last birthda) 126-24-0527 72 Yrs.   | / If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.                             | 8. Date of Birth<br>(Month, Day, Y<br>April 28, | 9. Birthplace (State or Foreign<br>Country) MA                    |
|                     | and  | -                 | Usual Residence of Decedent           10a. State         10b. County         10c. City, Town or It   | ocation  |   | 10d. Inside City Limits   |
|                     | Manyl<br>f sho   | ō                 | MD Baltimore Cockeys   | ville  |   | 1 ☐ Yes 2X No   |
|                     | 28a  | Director          | 10e. Street and Number   | 10f. Zip Code  | 100   | p. Citizen of What Country?                                       |
|                     | 3a or  | Ö                 | 40 Iron Mill Garth   | 21030  |   | USA   |
|                     | death<br>ms 2  | Jere              | 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1955  | . Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto         | pecify Yes or No-                               | 14. Race - American Indian,                                       |
| 936                 | permit. Pages 1 and 2 should be liled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, if a Medical Examinar must be notified at once. | by Funerai        | 1 Never Married 2 Married 1 Never Married 2 Married 3 Widowed 4 Divorced  Amed Forces? 1955 1 Myse, Give No 1957 Year or Dates:  | 1 ☐ Yes 2 💢 No Specify:  | o Rican, etc.)                                  | Black, White, etc.  Specify: White                                |
| ğ                   | 2 hor  | Completed         |  | edent's Usual Occupation<br>re kind of work done during most of wor                    | rking 16  | Bb. Kind of Business/Industry                                     |
| 2                   | hin 7<br>9.<br>Me 1  | pie               | (Specify only highest grade completed)  (Giv.   Elementary/Secondary (0-12)   College (1-4or 5+)   | DO NOT use retired)  | Killy   |   |
| 2                   | d wit<br>giene<br>er the   | Om                |  | sion-Chief   | 5   | Social Security   |
| 2                   | at Hygie<br>d other<br>vent, II  | Be (              | 17. Father's Name (First, Middle, Last)  |  | me (First, Middle, Ma                           |   |
| Maryland 21215-0036 | should bind Ment<br>marked<br>umatic e   | 2                 |  | Helen Miling Address (Street and Number or Ru  | ıral Route Number, (                            |   |
|                     | 1 and 2<br>Health a<br>om 27 Is  |                   | 20a Method of Disposition 20b. Place of Dis  | Iron Mill Garth, Coosition (Name of  | Date 20   | .le, MD. 21030  |
| Baltimore,          | Pages<br>ment of It<br>ant: If its<br>ury or o'  |                   | 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 1 ☐ Donation 5 ☐ Other (Specify)   | latteA Wew Parous  | 23/05   | Timonium, MD.   |
| Balt                | permit. Depart Import any inj  |                   | 21. Signature of Funeral Service Licensee  | 22. Name and Address of Facility<br>1050 York Road, To                                 | RUCK TOWS                                       | on Funeral Home, Inc.<br>21204                                    |
|                     | क्ष  |                   | 23a. Part 1. Enter the disease, or complications that caused the death. Do not e shock, or heart failure. List only one cause on each line.  | nter the mode of dying, such as cardiac  | or respiratory arres                            | Interval Between  |
|                     | Physician  |                   | 00   | rastric Cance  | 9 ~   | Onset and Death   |
|                     | /Medical   |                   | resulting in death)  Due to (or as a consequence of):  | as in C  |   | 2/2/5   |
| L                   | Examiner   |                   | Sequentially list conditions b.  |  |   |   |
|                     | D =  | ner               | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury  |  |   |   |
| P                   | cuted<br>nd<br>transi  | Examiner          | that initiated events C.   |  |   |   |
| O                   | ate be executed<br>hysician and<br>the burial-transit  |                   | resulting in death) Last Due to (or as a consequence of):  |  |   |   |
| 8760,               | ate br   | Ica               | d  |  |   |   |
| 9                   | leath certificate be executed<br>attending physician and<br>I for use as the burial-transit  | Med               | IF FEMALE:   |  |   |   |
| Вох                 | ath ce<br>ttend  | an/               | 23b. Was decedent pregnant  23c. If yes, outcome of pregnancy  1 Live birth 2 Fetal death  | Ectopic pregnancy  |   | 23d. Date of delivery  Month Day Year                             |
| 0.                  | ne death<br>the atter<br>hed for u   | Physician/Medical | 1 ☐ Yes 2 ☐ No 9 ☐ Unknown   | Other (specify)  |   |   |
| Θ.                  | that the de<br>ned by the a<br>detached f  |                   | Part II. Other significant conditions contributing to death but not resulting in the   | underlying cause given in Part I   | 23e. Did toba                                   | cco use contribute to the cause of death?                         |
| ords,               | law requires t<br>as been signe<br>2 should be o   | ted by            |  |  |   | 2 No 3 Probably 4 Ninknown  |
| Vital Records,      | 0 = 0  | Completed         |  |  | 24a. Was an<br>autopsy<br>performe              |   |
| tal                 | tician: Th<br>certificate<br>rector, pag   | CO                | 25. Was case referred to medical   | 26 Place of De   | 1 ☐ Yes 2<br>ath (Check only one)               |   |
|                     | Physician:<br>this certific<br>ral director,   | O B               | examiner? 1   Yes   2   O  | Other  |   | ce 6 ☐Other (Specify)   |
| 1 0                 | g Phys<br>er this<br>eral di   | L.                | 27. Manner of Death 28a. Date of Injury 28b. Time  | of 28c. Injury at  | 28d. Describe how                               |   |
| ion                 | Attending I<br>r death.<br>ector: After<br>by the funer  | atio              | 1. Statural 5 Pending (Month, Day Year) Injury 2 Accident investigation  | M 1 Yes 2 No   |   |   |
| Division            | t or Attence<br>after death<br>Director:   | ific              | 3 Suicide 4 Homicide  6 Could not be determined  28e. Place of Injury - At home, farm, building, etc. (Specify)  | street, factory, office  | 28f. Location (Stree                            | eet and Number or Rural Route Number,<br>State)                   |
|                     | tat or A   | Certification:    | building, sto. (Spoot))  |  |   |   |
|                     | To the Hospitat or Attending i within 24 hours after death.  To the Funeral Director: After completely filled in by the funer  | edicai            | 29a. Certifier (Check only one)    Description one   Check only one   Check on | ath occurred at the time, date and place investigation, in my opinion, death occurred. | e, and due to the cau<br>urred at the time, dat | use(s) and manner as stated. e and place, and due to the cause(s) |
|                     | To the within 2 To the complet   | Me                | 29b. Signature and title of certifier  | 29c. License number  |   | d. Date signed (Month, Day, Year)                                 |
|                     |  |                   | ( Kibut ) megun  | D0056919   |   | 12/22/05  |
|                     | 10+1   |                   | 30. Name and address of person who completed cause of death (Item 23a) (Type Robert Donegar, M.D. 6701 N. Ch   | e, Print)<br>arles Street, Tows  | son, MD.  | 21204   |
|                     | St.<br>Regist  | ate               | 31. Date filed (Month, Day, Year) DEC 2 3 2005   |  |   |   |
|                     | . negisi   | Tul               | THE PART OF THE PA |  |   |   |

|                            |   |                | For<br>Stete<br>Registrar   | State of   | Marylan   |                                |   | t of Health<br>e of Deat              |   | lental Hyg                            | giene<br>Nog. No.           | 05                             | 415                               | 15                   |
|----------------------------|---|----------------|---|--|---|--------------------------------|---|---------------------------------------|---|---------------------------------------|-----------------------------|--------------------------------|-----------------------------------|----------------------|
|                            | Dhuaisi   |                | 1. Decedent's Name (First, Middle   | , Last)  |   |                                |   |                                       |   | 2. Date of Dea<br>Month               |                             | Year                           | 3. Time of                        | Death                |
|                            | Physicia<br>/Medic  |                |   | JOSEPH   |   | HOURI                          | · ·                                     |                                       |   | DECEMBE                               |                             | 2005                           | 4:50                              | A <sup>M</sup>       |
|                            | Examin  | er             | 4a. Facility Name (If not institution   |  |   |                                |   | Town, or Location                     | on of Death   |                                       |                             | inty of Death                  | _                                 |                      |
| 41                         |   |                | GREATER BALTIM  5. Social Security Number   |  | AL CENT   |                                |   | ISON                                  | ler 24 Hrs.   | 8. Date of Birtl                      | 2                           | LTIMOR                         |                                   | Comina               |
| 2.                         | Funeral Director  |                | 146-46-8804   | M 2□F  | 5. Age ( <i>III yi</i> s. 1                         |                                | Months                                  |                                       |   | 11/29                                 | , Year)                     | Coun                           | olace (State of<br>otry)<br>JERSI | -                    |
|                            | 791   |                | Usual Residence of Decedent   |  |   |                                |   |                                       |   | 11/49/                                | 1931                        | 114 E W                        | JEKS                              | E. Y                 |
|                            | arylan<br>ehow  | _              | 10a. State 10b. County  |  |   | y, Town or Lo                  |   |                                       |   |                                       |                             | 1                              | 0d. Inside Ci                     |                      |
|                            | 986-1 e   | Director       |   | JSSEX  | Н   | OPATC                          |   | _                                     |   |                                       |                             |                                | 1 🗌 Yes                           | 2 A NO               |
| 2                          | 72 hours after death with the Maryland<br>"neturel", or items 23a or 28e-f ehow<br>idical Examinet must be notified at  |                | 10e. Street and Number<br>20 ADAMS TF   | RAIL   |   |                                | 10f. Zip                                |                                       | 843   |                                       | 10g. Citizen<br>USA         | of What Coun                   | try?                              |                      |
| 3                          | leath<br>ms 23  | Funeral        | 11. Marital Status  | 12. Was Deced  | dent Ever in U.                                     | S. 13.                         | Was Deced                               |                                       |   | ecify Yes or No-                      |                             | Race - Americ                  | an Indian,                        |                      |
| N, e                       | or iter   | Fun            | 1 XNever Married 2 Marr   | Armed Ford   | 2 [ <b>X</b> No                                     |                                |   |                                       |   | ecify Yes or No-<br>Rican, etc.)      |                             | Black, White,                  | etc.                              |                      |
| 000                        | irei', c  | d by           | 3 Widowed 4 Divorced  | If Yes, Give<br>Year or Dat                                | tes:  |                                | TU Yes 2                                | 2 X No Spec                           | rry:  |                                       | Spe                         | ocify: WHI                     | TE                                |                      |
| 3.5                        | "natu   | Completed      | 15. Decedent<br>(Specify only highes  | 's Education<br>t grade completed)                         |   | (Give                          | dent's Usua<br>kind of wor<br>DO NOT us | Occupation<br>k done during m         | ost of work   | ing                                   | 16b. Kind o                 | f Business/Inc                 | Justry                            |                      |
| 5                          | within<br>ene.<br>than "  | dmo            | Elementary/Secondary (0-12)   | College (1-  | 4or 5+)   |                                |   | DESIG                                 | NER   |                                       | SALI                        | 15                             |                                   |                      |
| 3 5                        | illed<br>Hygo<br>other  | Be C           | 17. Father's Name (First, Middle,   |  |   |                                |   | 18. Mo                                |   | e (First, Middle,                     |                             |                                |                                   |                      |
| 2                          | uld be<br>Menta<br>rrked<br>rice  | ToB            |   | JOSEPH 1   |   | DURIG                          | AN, J                                   | R. F                                  | OSEA  | NN M.                                 | BLAKI                       | ĿΕΥ                            |                                   |                      |
| Tal                        | ges 1 and 2 should be filed within 72 hours after death with the Maryla it of Heatth and Mental Hyglene. If item 27 is marked other than "naturel", or items 23a or 28e-f ehoo or other traumatic event, the Medical Examinat must be notified at   |                | 19a. Informant's Name/Relations   |  |   |                                | •                                       | ,                                     |   | al Route Numbe                        |                             |                                | Code)                             |                      |
| E, N                       | 1 end<br>1eaith<br>sm 27<br>ther ti   | 6              | JACQUELINE T  20a. Method of Disposition  | . HOURIGA  |   |                                |   |                                       |   | PATCON                                |                             | on - City or To                |                                   |                      |
| 0                          | permit. Pages<br>Department of I<br>Important: If Ite<br>any injury or of   |                | 1 ☐ Burial 2 XI Cremation   |  | iaie  | lace of Dispo                  |   |                                       | į<br>į  |                                       |                             |                                |                                   |                      |
| alt I                      | artme<br>ortan<br>injury  |                | 4 □ Donation 5 □ Other (S)  21. signature of F and Source   |  | АЬЬ   |                                |   |                                       |   | 23/05<br>LETCHER                      |                             |                                |                                   |                      |
| B                          | Departiment of the particular in the particular |                | VIII  |  |   | i                              |   |                                       |   | WESTMI                                |                             |                                |                                   | 57                   |
|                            | 7 7   |                | 23a. Part1. Enter the disease or shock, of heart failure. List  | complications that ca                                      | used the death                                      |                                |   |                                       |   |                                       |                             |                                | Approximat<br>Interval Bet        | е                    |
|                            | Physician   |                | Immediate Cause (Final disease or condition   | $\mathcal{O}$  |   | Meta                           | istas                                   | 185                                   |   |                                       |                             |                                | Onset and I                       | Death                |
| -                          | /Medical<br>Examiner  |                | resulting in death)   | Due to (o  | or as a consequ                                     | uence of):                     |   | - ( )                                 |   |                                       |                             | 1                              | 200                               |                      |
| <i>\\ \\</i>               | 134   | <u>_</u>       | Sequentially list conditions,   | b. Tak   | LINOCAY   | CINO                           | ma                                      | of Lu                                 | nas   |                                       | _                           | 400                            | _                                 |                      |
|                            | uted<br>d<br>anslt  | Examiner       | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events |  | ,   |                                |   |                                       |   |                                       |                             |                                |                                   |                      |
| ó                          | exec<br>an an<br>rial-tra   |                | resulting in death) Last  | C. Due to (o   | or as a consequ                                     | uence of):                     |   |                                       |   |                                       |                             |                                |                                   |                      |
| 8760,                      | cate be executed<br>physician and<br>the burial-transit   | dicai          |   | d  |   |                                |   |                                       |   |                                       |                             |                                |                                   |                      |
| ဟ                          | entific<br>ling pl  | Med            | IF FEMALE:  | 02- 4  |   |                                |   |                                       |   |                                       |                             |                                |                                   |                      |
| Вох                        | eath certifi<br>attending  <br>I for use as   | lan            | 23b. Was decedent pregnant in the past 12 months?   |  | ome of pregna<br>rth 2 ☐ Fetal<br>int at time of de | death 3                        | Ectopic pre                             |                                       |   |                                       | 23d.                        | Date of delive<br>Month        |                                   | Year                 |
| P.O.                       | that the death<br>ed by the atte<br>detached for  | Physician/Me   | 1 ☐ Yes 2 ☐ No<br>9 ☐ Unknown   | 9☐ Unknov  |   | 54.01                          | _ Other (spe                            | scily)                                |   |                                       |                             |                                |                                   |                      |
| ٥,                         | Attending Physicien: The law requires that the death certific rideath. ector: After this certificate has been signed by the attending pot the funeral director, page 2 should be detached for use as  | by PI          | Part II. Other significant condition  | ns contributing to dea                                     | ath but not resu                                    | ulting in the u                | nderlying ca                            | ause given in Pa                      | rt I.   | 23e. Did to                           | bacco use o                 | ontribute to th                | e cause of d                      | leath?               |
| ords                       | w require<br>been sig<br>should b   |                |   |  |   |                                |   | ····                                  |   | 1 □ Y                                 | es 2□N                      | 3 Prob                         | ably 4                            | Jnknown              |
| Division of Vital Records, | iawrias be  | Completed      |   |  |   |                                |   |                                       |   | 24a. Was a                            | sy                          | b. Were autor                  | psy findings<br>npletion of c     | available<br>ause of |
| <u> </u>                   | cate r  | Con            |   |  |   |                                |   |                                       |   | perfor<br>1 Yes                       | med?<br>2 XX No             | death?<br>1 🗌 Yes              | 2 🗆 No                            |                      |
| Vita                       | sician<br>certifi<br>rector   | Be             | 25. Was case referred to medical examiner?  | diameter .   |   |                                |   | Othon                                 |   | h (Check only or                      |                             |                                |                                   |                      |
| of                         | Phys<br>or this<br>oral di  | To It          | 1 ☐ Yes 2 No<br>27. Manner of Death   | 28a. Date of   |   | ER/Outpatier<br>28b. Time o    |   | Bc. Injury at Work?                   |   | me 5 Resid                            |                             |                                | )                                 |                      |
| ion                        | Attending<br>death.<br>ctor: Afte<br>y the fune   | atior          | 1 Natural 5 Pendin<br>2 Accident investig   |  | n, Day Year)  | Injury                         | М                                       | Work?<br>1 ☐ Yes 2                    | □No   |                                       |                             |                                |                                   |                      |
| ivis                       | r Atte  | Certification: | 3 ☐ Suicide 6 ☐ Could r<br>4 ☐ Homicide determ  | inad 289. Place C  | of Injury - At ho<br>g, etc. (Specify               | me, farm, str                  | eet, factory                            | , office                              |   | 28f. Location (S<br>City or Tow       | treet and Nu                | mber or Rura                   | Route Num                         | ıber,                |
| Q                          | urs aft   |                |   |  |   |                                |   |                                       |   |                                       |                             |                                |                                   |                      |
|                            | To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2  | Medical        | 29a. Certifier 1 Certifyin (Check only 2 Medical:   | g Physician: To the b<br>Examiner: On the bas<br>and manne | sis of examinal                                     | wledge, deat<br>tion and/or in | h occurred a<br>vestigation,            | at the time, date<br>in my opinion, o | and place, and place, and place and | and due to the o<br>ed at the time, o | ause(s) and<br>late and pla | manner as sto<br>e, and due to | ated.<br>the cause(s              | ;)                   |
|                            | ro the<br>within<br>Fo the  | Me             | 29b. Signature and title of certifier   |  |   |                                | 29c                                     | . License numbe                       | ər  | 2                                     | 29d. Date sig               | ned (Month, I                  | Day, Year)                        |                      |
|                            |   |                | luren   | e chali  |   |                                | 1                                       | 004                                   | 4018  | 3                                     | 12-7                        | 22-20                          | 05                                |                      |
| ex                         |   |                | 30. Name and address of person  | who completed cause  | of death (Item                                      | _                              | Print)                                  | 2                                     | ,   | e mo                                  |                             |                                |                                   | -                    |
| 0,                         | J   |                | 31. Date filed (Month, Day, Year)   | . Obah   | gistrar's Signa                                     | CIBI                           | 4C                                      | Bal                                   | timor   | e mo                                  | 212                         | 04                             |                                   |                      |
| ha                         | Sta<br>Registr  |                | DEC 2 3   | 2005   | Janus Sigila  | k de                           | and)                                    |                                       |   |                                       |                             |                                |                                   |                      |

|                                     |   |                     | For   | State of Mary                                       | rland / Depa                          | artment of H                          | Health and M                           | Mental Hygie                                  | ne                             | 1.1516   |
|-------------------------------------|---|---------------------|---|---|---------------------------------------|---------------------------------------|--|---|--------------------------------|--|
|                                     |   |                     | 1 - State<br>Registrar  | 1   | Cel                                   | rtificate of                          | Deam                                   |   | N2005                          | 4 1 J 1 O  |
|                                     | Physicia  | an                  | 1. Decedent's Name (First, Middle, Last, Karl Hackl   | ,   |                                       |                                       |  | Date of Death     Month                       | Day Year                       | 3. Time of Death                                 |
|                                     | /Medic  |                     |   |   |                                       |                                       |  | December                                      | 20 2005                        | 9:00p <sup>M</sup>                               |
| 7                                   | Examin  | er                  | 4a. Facility Name (If not institution, give   |   |                                       |                                       | or Location of Death                   | 1   | 4c. County of Dea              | th   |
|                                     |   |                     | Carroll Hospital  |   | and birth days                        | Westmins<br>If Under 1 Year           |  | 0.000000000                                   | Carroll                        |  |
|                                     | Funeral   |                     | 5. Social Security Number 6. Se 219-34-4611   | x 7. Age (#   | n yrs. last birthday)<br>Yrs.         | Months Days                           |  | 8. Date of Birth<br>(Month, Day, Y<br>June 18 | ear) 9. Bir                    | thplace (State or Foreign ountry)                |
|                                     | Director  |                     | Usual Residence of Decedent   | 13  |                                       |                                       |  | June 18                                       | 1930 Ge                        | rmany  |
|                                     | land  |                     | 10a. State 10b. County  | 10  | c. City, Town or Lo                   | ocation                               |  |   |                                | 10d. Inside City Limits                          |
|                                     | Mary  | ğ                   | Md Carroll  |   | Sykesvil:                             | le                                    |  |   |                                | 1 ☐ Yes 2 ☐ No                                   |
|                                     | 28s   | rec                 | 10e. Street and Number  |   |                                       | 10f. Zip Code                         |  | 100   | . Citizen of What Co           | ountry?  |
|                                     | be filed within 72 hours atter death with the Maryland Hygiene. d other then "natural", or items 23a or 28a-f ehow event, the Modical Examinar must be notified at  | by Funeral Director | 6630 Sykesville R   | oad   |                                       | 21784                                 |  | Į   | JSA                            |  |
|                                     | death<br>ms 2   | era                 | 11. Marital Status  | 12. Was Decedent Eve                                | r in U.S. 13.                         | Was Decedent of H                     | Hispanic Origin? (Span, Mexican, Puert | pecify Yes or No-                             | 14. Race - Ame                 |  |
| 20                                  | atter at  | F                   | 1 Never Married 2 Married   | Armed Forces?<br>1 ☐ Yes 2 ☐ No<br>If Yes, Give X   | ļ                                     |                                       |  | o Hican, etc.)                                | Black, Whi                     |  |
| 8                                   | urs a   | by                  | 3 XWidowed 4 ☐ Divorced   | If Yes, Give A.<br>Year or Dates:                   |                                       | 1 ☐ Yes 2 🔀 No                        | Specify:                               |   | Specify: wh                    | ite  |
| 9                                   | 72 ho   | Completed           | 15. Decedent's Edu<br>(Specify only highest grad  | cation  |                                       | dent's Usual Occup                    | pation<br>during most of wor           | king 16                                       | b. Kind of Business            | /industry  |
| 2                                   | La Caraciana  | ple                 | Elementary/Secondary (0-12)   | College (1-4or 5+)                                  | life.                                 | DO NOT use retire                     | d)                                     | , , , ,                                       |                                |  |
| 7                                   | filed within 72. Hygiene. other then "nat   | ő                   | 12  |   | Da                                    | aker                                  | ,                                      |   | food se                        | rvice  |
| 2                                   | a H oth   | Be                  | 17. Father's Name (First, Middle, Last)   |   |                                       |                                       |  | ne (First, Middle, Ma                         | iden Sumame)                   |  |
| <u>8</u>                            |   | ဥ                   | George Hackl  |   |                                       |                                       | unknow                                 | n   |                                |  |
| ᡖ                                   | S E E   | 1 3                 | 19a. Informant's Name/Relationship (T)  |   |                                       | -                                     |  | ral Route Number, C                           |                                |  |
| <b>≥</b>                            | and<br>eelth<br>Eelth   |                     | Rose Crouse (daug   |   |                                       |                                       |  |   |                                |  |
| ore<br>Ore                          | of H<br>of H<br>if ite  |                     | 20a. Method of Disposition 1 □ Burial 2 ☒ Cremation 3 □ F   |   | 20b. Place of Dispo<br>cemetery, crei |                                       |  |   | c. Location - City or          | Town, State                                      |
| E                                   | permit. Pages 1 and 2 Depertment of Heelth a important: if item 27 is any injury or other tra   |                     | 4 ☐ Donation 5 ☐ Other (Specify)  |   |                                       |                                       | cion [12-2]                            |   | kesville                       |  |
| Baltimore,                          | epert<br>epert<br>ny in   |                     | 21. Signature of Funeral Service Licens Puge House S  | Joshant   | 22                                    | 2. Name and Addre                     | ess of Facility Ha                     | aight Fune                                    | eral Home                      | & Chapel   |
| _                                   | 20 E 3 G  |                     |   |   |                                       |                                       |  | ville, Md                                     |                                |  |
|                                     |   |                     | 23a. Part1. Enter the disease, or compi<br>shock, or heart failure. List only o                             | lications that caused the<br>ne cause on each line. | death. Do not ent                     | ter the mode of dyi                   | ng, such as cardiad                    | or respiratory arres                          | ,                              | Approximate<br>Interval Between                  |
| 1                                   | Physician   |                     | Immediate Cause (Final disease or condition   | . Co  | valia                                 | e a                                   | WHYF                                   | hmile   |                                | Onset and Death                                  |
|                                     | /Medical<br>Examiner  |                     | resulting in death)   | Due to (or as a co                                  | onsequence of):                       | - 1                                   | ,                                      | hmia<br>13easo                                |                                |  |
|                                     | CXammer   |                     | Sequentially list conditions.   | b. COY  | nary                                  | Carter                                | 7 1                                    | 15caso  |                                |  |
|                                     | D =   | Examiner            | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | Due to (or as a co                                  | onsequence of):                       |                                       |  |   |                                |  |
|                                     | ecute<br>end<br>-trans  | саш                 | that initiated events resulting in death) Last  | c<br>Due to (or as a co                             | annaguanaa afti                       |                                       |  |   |                                |  |
| ,60                                 | te be executed<br>ysicien end<br>te burial-transit  | calE                |   | Due to (or as a co                                  | onsequence on,.                       |                                       |  |   |                                |  |
| -                                   | physi<br>the b  |                     | •   | d   |                                       |                                       |  |   |                                |  |
|                                     | ding I  | /Me                 | IF FEMALE:  | 23c. If was outcome of s                            | V0000000V                             |                                       |  |   |                                |  |
| 8                                   | ath c<br>attend<br>for us   | lan                 | 23b. Was decedent pregnant in the past 12 months?   | 23c. If yes, outcome of p<br>1 ☐ Live birth 2       | Fetal death 3                         | Ectopic pregnanc                      | y                                      |   | 23d. Date of de<br>Month       | livery<br>Day Year                               |
| o.                                  | the the   | slc                 | 1 ☐ Yes 2 ☐ No<br>9 ☐ Unknown   | 4⊡Pregnant at tim<br>9⊡Unknown                      | e or death 5 t                        | Other (specify) _                     |  |   |                                | ŕ  |
| Division of Vital Records, P.O. Box | Attending Physicien: The law requires thet the death certifical robath. robath. sctor: Atter this certificete has been signed by the attending phy the tuneral director, page 2 should be detached for use as the | by Physician/Med    | Part II. Other significant conditions co  | ntnbuting to death but n                            | ot resulting in the u                 | Inderlying cause di                   | ven in Part I                          | 23e. Did toba                                 | cco use contribute t           | o the cause of death?                            |
| Š                                   | sign<br>a pe  | d b                 | HyperLens   | ien   |                                       |                                       | 20.000                                 |   |                                | robably 4 □Unknown                               |
| Ö                                   | redu  | etec                | Diabet  | 00 100  | ellitus                               |                                       |  |   |                                |  |
| န္တ                                 | e law<br>has l  | Completed           | Diaver  | es mi   | CULIFUS                               | · · · · · · · · · · · · · · · · · · · |  | 24a. Was an autopsy performe                  | d? 24b. Were a prior to death? | utopsy findings available completion of cause of |
| =                                   | cete  |                     |   |   |                                       |                                       |  |   |                                | s 2□ No  |
| ⋚                                   | ician<br>Sertifi<br>ector   | Be                  | 25. Was case referred to medical examiner?  | Hospital: 9   |                                       | <b>.</b>                              | 26. Place of Dea                       | th (Check only one)                           |                                |  |
| <u>o</u>                            | Phys<br>this<br>at dir  | 2                   | 1 Yes 2 No  | Hospital: 1 Inpatient 28a. Date of Injury           | 2 ER/Outpatie                         | III SEALDON                           | 4 🗀 Nursing n                          | ome 5 Residen                                 |                                | ecify)   |
| 2                                   | ling Alter  | lo<br>lo            | Natural 5 Pending   | (Month, Day Ye                                      | ear) 28b. Time o                      | Wo                                    |  | 28d. Describe how                             | injury occurred                |  |
| S                                   | ttsnd<br>death<br>tor:<br>the   | cat                 | 2 Accident investigation 3 Suicide 6 Could not be   | One Olean of Injury                                 | At home for at                        |                                       | ]Yes 2□No                              | 20f Location (Str.                            | ot and Number of D             | hand Davids Alvanta                              |
| <u>≥</u>                            | or A<br>atter<br>Direction by   | Certification;      | 4 Homicide determined   | 28e. Place of Injury<br>building, etc. (            | Specify)                              | теет, тастогу, опісе                  |  | City or Town,                                 | et and Number or R<br>State)   | urai Houle Number,                               |
| _                                   | ours i  |                     | 29a. Certifier Certifying Phy   | vsician: To the best of m                           | v knowledge dest                      | th occurred at the t                  | ima data and place                     | and due to the com                            | so(s) and massar =             | e stated   |
|                                     | To the Hospital or Attending Physician: The law within 24 hours after death. To the Funarel Director: After this certificate has completely lilled in by the funeral director, page 2                             | Medical             | (Check only one)  | iner: On the basis of ex<br>and manner stated       | amination and/or in                   | ivestigation, in my                   | opinion, death occu                    | rred at the time, date                        | and place, and du              | e to the cause(s)                                |
|                                     | o the   | Me                  | 29b. Signature and title of certifier   | A-  |                                       |                                       | se number                              | 290   | . Date signed (Mon             | th, Day, Year)                                   |
|                                     | - > - 0   |                     | Norgan Vo   | yward h   |                                       | 023                                   | 3 Leh3                                 |   | 2 216 27                       | -  |
|                                     | 5   |                     | 30 Name and address of person who o   | ompleted cause of deat                              | h (Item 23a) (Type                    |                                       |  | n 146   | est-m1                         | rster  |
|                                     |   |                     | 30. Name and address of person who c  | TLA MD  | 1130 3                                | altimo                                | re BII                                 | A M   | \$ 21                          | 157  |
|                                     | Sta   | ite                 | 31. Date filed (Month, Day, Year)   | 32. Registrar's                                     | Signature                             | 1                                     |  |   |                                | -  |
|                                     | Regist  |                     | DEC 2 3 2   | 2005  | a St. L                               | market                                |  |   |                                |  |

State Registrar

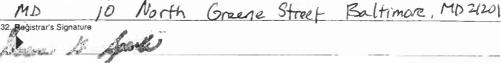
DHMH 17 Rev 1/2001

31. Ďate filed (Month, Day, Year)
DEC 2 3 2005

Gandhi

30. Name and address of person wi

+mish



completed cause of death (Item 23a) (Type, Print)

05-08344 Unpend I tems: 23a & 27 per MEO G-851 1/21/06 reb State of Maryland / Department of Health and Mental Hygiene Roscoe Jackson Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Roscoe Jackson December 10. 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington County Hospital Washington Birthplace (State or Foreign
 Country) 8. Date of Birth (Month, Day, Year) 1 - 14-56 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 XM 2 ☐ F 218-64-2180 49 Yrs. Director Usual Residence of Decedent Maryland 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Heelth and Mental Hyglene. Important: If Item 27 is marked other than "naturel", or Iteme 23a or 28s-f ehow any Injury or other treumatic event, the Madical Examinat must be notified at once. MD Baltimore XXYes 2 No Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3809 Bonner Rd. 21244 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ② 1 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 1XX ever Married 2 ☐ Married Maryland 21215-0036 1 Yes 2 No Black P Specify 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Moving And Hauling 12th Moving and Storage 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Odoris Willburn 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2926 Rosalynd Ave, Balto. 21215 Jerrod G. Jackson (Son) Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Dundalk, MD Bayview Crematory 12-21-05 22. Name and Address of Facility Wesley Chavis Jr. FH 21. Signature of Funeral S 2007 Eastern Ave. Balto. 21231 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one dause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Intracerebral Hemorrhage Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leaving to immediate cause. Enter Underlying Cause (Disease or injury that initiated ease or injury) Dua to (or as a consequence of) Examiner physicien and the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical use as the IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 2 ☐ Fetal death 3 Ectopic pregnancy ō in the past 12 months? Month Day Year 5 ☐ Other (specify) P.O. P Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, page 2 should be 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☑ Yes 2 ☐ No autopsy performed? 1 Yes 2 □ No 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ∏ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Yes 2 No Certification: To 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 1 XNatural 5 Pending after death. М investigation 1 □ Yes 2 □ No 2 Accident the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 🗌 Homicide within 24 hours at To the Funerel D completely filled i 29a Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and memor as stated Medicai (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d, Date signed (Month, Day, Year)

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Segistrar's Signature.

Southeell

31. Date filed (Month, Day, Year)

DF() 2 2

O.C.M.E.

111 Penn Street, Baltimore, Maryland 21201

December 13, 2005

|                     |  |                     | For<br>State<br>Registrar  |  | State of Ma  | arylar           |  |                                  |                              | lealth ai<br>Death                        | nd M                |  | giene<br>Reg. No     | UUJ                                  | The state of the s | 1519                                      |
|---------------------|--|---------------------|--|--|--|------------------|--|----------------------------------|------------------------------|---|---------------------|--|----------------------|--------------------------------------|--|---|
| 4                   | Physici  |                     | 1. Decedent's Name<br>Florence   | e (First, Middle, Last)<br><b>Johns</b>                      |  |                  |  |                                  |                              |   |                     | 2. Date of De<br>Month                           | Da                   |                                      | ar   | 3. Time of Death                          |
|                     | /Medio<br>Examin   |                     | 4a. Facility Name (I   | f not institution, give<br>ium Health                        | street and number)  1 & Rehab  | . Cer            | nter of  | 4b. City<br>Ell                  | Town, or                     | Location of City                          | Death               | 12/19  |                      | County of D<br>Howard                |  | 2:15pm™                                   |
| ×                   | Funeral<br>Director  |                     | 5. Social Security N<br>219-30-<br>Usual Residence of  | 3647   | 7. Ag  | e (In yrs.<br>91 | last birthday)<br>Yrs.   | If Unde<br>Months                | r 1 Year<br>Days             | If Under 24<br>Hours                      | 4 Hrs.<br>Min.      | 8. Date of Bir (Month, Da 7/21/                  | ıy, Year)            | 1                                    | Birthpla<br>Count  | ace (State or Foreign<br>ry)<br>MD        |
|                     | yland  |                     | 10a. State   | 10b. County  |  | 10c. Ci          | ty, Town or Lo   | cation                           |                              |   |                     |  |                      |                                      | 10   | d. Inside City Limits                     |
|                     | e Mar  | ctor                | MD   | НС   | ward   |                  |  | Elli                             | cott                         | City                                      |                     |  |                      |                                      |  | 1 □ Yes 2 <b>∑X</b> o                     |
|                     | h with th  | ai Dire             | 3000 No:   | nber<br>rth Ridge  | Road   |                  |  | 10f. Zi                          | Code                         | 21  | 043                 |  | 10g. Ci              | tizen of What<br>US                  |  | ry?                                       |
| 980                 | be filed within 72 hours after death with the Maryland tal Hygiene.  Ided other than "naturel", or iteme 23e or 28e-f ehow event, the Medical Examinar must be notilled at | by Funeral Director | 11. Maritaf Status<br>1 ☐ Never Marri<br>3 ☑ Widowed   | ied 2 Married<br>4 Divorced                                  | 12. Was Decedent<br>Armed Forces?<br>1 ☐ Yes 2 ☑<br>If Yes, Give<br>Year or Dates: |                  | l:   | Vas Dece<br>fYes, spe<br>l □ Yes | cify Cuba                    | ispanic Origi<br>In, Mexican,<br>Specify: | n? (Spe<br>Puerto I | ocify Yes or No<br>Rican, etc.)                  | )-                   | 14. Race - A<br>Black, W<br>Specify: |  |   |
| Maryland 21215-0036 | e filed within 72 ho<br>al Hygiene.<br>I other than "natur<br>vent, I'n Medical  | Completed           | (Spec<br>Elementary/Seco<br>12   | 15. Decedent's Edu<br>ify only highest grad<br>indary (0-12) | cation<br>e <i>completed)</i><br>College (1-4or t                                  | 5+)              | 16a. Deced<br>(Give<br>life. L   | kind of wo                       | rk done d                    | during most o<br>()                       | of workii           | ng   | 16b. K               | and of Busine                        | ss/Indi  | ,   |
| land                | 2 should be filed and Mental Hygical and Mental Hygical I is marked other reumatic event, I  | To Be C             |  | (First, Middle, Last)<br>Atkinson                            |  |                  |  |                                  |                              |   |                     | (First, Middle,<br>A. Fra                        |                      | Sumame)                              |  |   |
|                     | nd 2 shou<br>alth and N<br>27 is main<br>r treumain  |                     |  | P. Saul/   |  |                  | 19b. Mailin<br>2105  | g Addres<br>Ridge                | s (Street e                  | and Number<br>Drive                       | or Rura             | I Route Number                                   | er, City o           | or Town, State<br>larylar            | е, <i>Zip (</i>  | <sup>Code)</sup><br>21048                 |
| Baltimore,          | permit. Pages 1 and 2 should b<br>Department of Health and Ments<br>Important: if Item 27 is marked<br>eny injury or other treumatic e<br><u>once.</u>                     |                     |  | osition Cremation 3 F 5 Other (Specify)                      | lemoval from State   | 20b. F           | Place of Disponentery, crentary, cre | sition (Na<br>natory or i        | me of<br>other place<br>EST  | /etera                                    | ns C                | cem. 12  | <sup>20c.</sup> L    | ocation - City                       | or Tow   | wn, State MD<br>ngs Mills                 |
| Balti               | permit<br>Departn<br>Imports<br>eny Inju   |                     | 21. Signature of Fu  | neral Service Licens   | Victor I   | P. Do            | oda, Jr <sup>22</sup>  | Name a                           | nd Addres                    | s of Facility                             | vens                | Funer<br>ie, Bal                                 | al H                 | lome, I                              | nc.  |   |
| 37                  |  |                     | 23a. Part1. Enter the shock, or hea  | ne disease, or compl<br>rt failure. List only or             | cations that caused<br>ne cause on each li   | the deat         |  |                                  |                              |   |                     |  |                      | ic in                                |  | Approximate<br>Interval Between           |
|                     | Physician<br>/Medical  |                     | Immediate Cause disease or condition resulting in death)   | (Final   | End Stag   | e Co             | njestiv  | re He                            | art :                        | Failur                                    | re                  |  |                      |                                      |  | Onset and Death                           |
|                     | Examiner   |                     | , country  |  | Due to (or as ASCVD /  |                  |  | entia                            |                              |   |                     |  |                      |                                      |  |   |
|                     | uted d   | Examiner            | Sequentially list co<br>if any, leading to im<br>cause. Enter Unde<br>Cause (Disease or<br>that initiated events | mediate<br>rlying<br>injury                                  | Due to (or as  |                  |  |                                  |                              |   |                     |  |                      |                                      |  |   |
| ,0928               | cate be executed<br>physician and<br>the burial-transit  | dical Exa           | resulting in death) I  | Last   | Due to (or as  | a conseq         | quence of);  |                                  |                              |   |                     |  |                      |                                      |  |   |
| 9                   | entifical<br>ling phi<br>e as th   | Medi                | IF FEMALE:   |  |  |                  |  |                                  |                              |   |                     |  |                      |                                      |  |   |
| .O. Box             | The law requires that the death certificate be executed the has been signed by the attending physician and tage 2 should be detached for use as the burial-transit         | Physician/Me        | 23b. Was deceden in the past 12 1 ☐ Yes 2 2 ☐ Unknown  | months?  | 3c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown                     | 2 Feta           | aldeath 3□   | Ectopic p<br>Other (s)           |                              |   |                     |  |                      | 23d. Date of Month                   |  | y<br>Day Year                             |
| rds, P              | w requires that<br>been signed t<br>should be det:   | <u>م</u>            | Part II. Other signif  | icant conditions cor   | ntnbuting to death b   | ut not res       | sulting in the ur  | nderlying (                      | cause give                   | en in Part I.                             |                     |  | obacco i<br>Yes 2    | _                                    | to the   | cause of death?                           |
| Vital Records,      |  | Completed           |  |  |  |                  |  |                                  |                              |   |                     | 24a. Was<br>autor<br>perfo<br>1 \( \text{Yes} \) |                      | prior                                | to com   | sy findings available pletion of cause of |
| Vita                | Physician:<br>this certific<br>ral director,   | Be                  | 25. Was case refer examiner?   |  | lospital:  |                  |  |                                  | 1 01                         |   |                     | Check only o                                     |                      |                                      |  |   |
| ō                   |  | 7.<br>To            | 1 ☐ Yes 2 ☒☐<br>27. Manner of Deat   | Mo   | 28a. Date of Inju<br>(Month, Da  |                  | ER/Outpatien<br>28b. Time of   |                                  |                              | 4 6 34 401 2                              |                     | ne 5 Resid                                       |                      |                                      | pecify)  |   |
| ion                 | Attending I<br>r death.<br>ector: After<br>by the funer  | atlor               | 1 XXatural 2 ☐ Accident  | 5 Pending investigation                                      | (Month, Da   | y Year)          | Injury   | М                                | 28c. fnjury<br>Work<br>1 🔲 ' | (?<br>Yes 2. □No                          |                     |  |                      | , 5551.755                           |  |   |
| Division            | tel or Attend<br>s after death<br>el Director: ,<br>ed in by the f   | Certification;      | 3 ☐ Suicide<br>4 ☐ Homicide  | 6 Could not be<br>determined                                 | 28e. Place of Inj<br>building, et  | ury - At h       | ome, farm, stre  | eet, factor                      | y, office                    |   | 2                   | Bf. Location (8<br>City or Tov                   | Street an            | nd Number or<br>a)                   | Rural  | Route Number,                             |
|                     | To the Hospitel or within 24 hours after To the Funerel Director Completely filled in b  | Medicai             | 29a. Certifier<br>(Check only<br>one)  | 1XXCertifying Phys   | sician: To the best<br>ner: On the basis of<br>and manner sta                      | examina          | owledge, death<br>ation and/or inv   | occurred                         | at the tim                   | ne, date and pointion, death              | place, a<br>occurre | and due to the<br>ed at the time,                | cause(s)<br>date and | ) and manner<br>d place, and c       | as sta<br>fue to t   | ted.<br>he cause(s)                       |
| ,                   | To the within 2 To the complet   | Σ                   | 29b. Signature and   | 1 ( )  | m  |                  |  | 29                               | D30                          |   |                     |  |                      | te signed (Mo                        |  | -   |
|                     | 5  |                     |  | ess of person who co<br>Sabapath                             | mpleted cause of d   |                  |  |                                  | Posi                         | Dale                                      | i mere              | 2  | 1221                 |                                      |  |   |
| w'                  | Sta<br>Registi   |                     | 31. Date filed (Mon  |  | 3 negistr  | ar's Signa       | ature  | W)                               | T/AG(                        | - Dali                                    | HIOT                | e MD   |                      |                                      |  |   |

# EFFRIES, WILLIAM

Baltimore, Maryland 21215-0036 19a. Informant's Name/Relationship (Type, Print) Pages 1 and 2 s ment of Health an permit. Pages 1 and 2 Department of Health ar Important: If item 27 is any injury or other trau once. Emma Jeffries / Wife Dec 21, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 Cremation 3 Amenoval from State Piney Grove Church Cemetery \* 4 □ Donation 5 □ Other (Specify) 2005 21. Signature of Fogeral Service Licensee Immediate Cause (Final disease or condition resulting in death) Physician Sersis /Medical Due to (or as a consequence of): Examiner Agrizotion Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed Amio Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. λq Records. funeral director, page 2 should Be Completed Division of Vital Hospital or Attending Physicien: 25. Was case referred to medical examiner 1 Inpatient 2 ER/Outpatient 3 DOA Other: 1 Yes 2 3 No Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manne of Death 28b. Time of 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 24 hours after death. 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 29a. Certifier Medical (Check only one) 29c. License number 29b. Signature and title of certifier

State of Maryland / Department of Health and Mental Hygiene ( Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** William Jeffries 5-00 AM December 15 2005 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** BALTIMORE UNIVERSITY If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Days 1 M 2 □ F 57 237-76-5754 Yrs. Dec. 22, 1947 Director NC Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits other traumatic event, the Medical Examiner must be notified at MD Baltimore 1 FYes 2 No Director 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 5424 Daywalt Avenue 21206 USA or Items 23a Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ Yo If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 Yes 2 IN Specify: Black 3 ☐ Widowed 4 ☐ Divorced "natural" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) d 2 should be filed within 7, hand Mental Hygiene. 7 is marked other than "n. Elementary/Secondary (0-12) College (1-4or 5+) Iruck Driver Mus portation 10 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Jeffries Charlie Donnie Ausby ျ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5424 Daywalt Ave. Baltimore MD 21206 20c. Location - City or Town, State Jackson, NC 22. Name and Address of Facility
Charles L. Stevens Funeral Home Inc. 1501 Fast Fort Ave. Baltimore MD 21230 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Silvousis 23d. Date of delivery Month Day 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death? 2 No 2 No 1 Yes 1 Yes 26. Place of Death (Check only one) 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 29d. Date signed (Month, Day, Year) 12-15-2005 352749 KIRPARA M.D. TAYANT 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimere. Stret

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State Registrar

31. Date filed (Month, Day, Year)

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Unpend item#23a,27,28a-f,penH;,001,1/100 II

|   | 1 _ S           | or<br>ate<br>egistrar   |  |  | partment of Fertificate of   |                      |                                  | g. No.                        | 91061   |
|---|-----------------|---|--|--|--|----------------------|----------------------------------|-------------------------------|---|
| Physician   | 1. Dec          | edent's Name (First, Middle, L  |  | . Jiordano   | )  |                      | 2 Date of Death<br>December      | r 18, 2005                    | 3. Time of Death 16:00 M                          |
| /Medical<br>Examiner  | 4a. Fa          | cility Name (If not institution, g                                    |  |  |  | r Location of Death  |                                  | 4c. County of Deat            |   |
| Lxammer   | 10              | Monroe Street   | Apartment                                      | 101  | Rocl   | kville               |                                  | Montgom                       | erv   |
| Funeral   | 5. Soc          | al Security Number 6.   | Sex 7. A                                       | ge (In yrs. last birthda                                       |  |                      | 8. Date of Birth<br>(Month, Day, | O Rie                         | bologo /State or Fornia                           |
| Director  |                 | -48-0208  | 1 <u>X</u> M 2□F                               | 59 Yrs.  |  |                      | September                        | 27, 1946 Mic                  | hígan   |
| *   | Usual<br>10a. S | Residence of Decedent tate 10b. County                                |  | 10c. City, Town or   | Location   |                      |                                  |                               | 10d. Inside City Limits                           |
| r ehow  |                 | yland Montg   | nmerv  | Rockv  | ille   |                      |                                  |                               | 1 X Yes 2 No                                      |
| recto   |                 | treet and Number  | Janel y  | Rockv  | 10f. Zip Code  |                      | 10                               | og. Citizen of What Co        | puntry?   |
| event, the Medical Example at must be coulded at Be Completed by Funeral Director | 10              | Monroe Street   | . Apartmen                                     | nt 101   | 208  | 50                   |                                  | Jnited Stat                   | -   |
| Funeral Director  | 11. Ma          | rital Status  | 12. Was Deceden<br>Armed Forces                | t Ever in U.S. 13  | B. Was Decedent of H<br>It Yes, specify Cuba   | lispanic Origin? (Sp | ecify Yes or No-                 | 14. Race - Ame                |   |
| Ē   | 1[              | Never Married 2∑ Married  |  | No   | 1 ☐ Yes 2 ☑ No   | Specify:             | rican, etc.)                     | Black, Whit                   |   |
| d by  | 3 [             | ☐Widowed 4 ☐Divorced  | Year or Dates:                                 |  | 1 103 2 M  | opecity.             |                                  | Specify: Wh                   | 111e  |
| Completed   |                 | 15. Decedent's<br>(Specify only highest g                             |  | (Gir   | edent's Usual Occup<br>ve kind of work done  | during most of work  | ing                              | 16b. Kind of Business         | Industry  |
| ם   | Eler            | nentary/Secondary (0-12)  | College (1-4or                                 | 5+)  | . DO NOT use retired   | ,                    | 1                                | Federal Gov                   | zowen on t  |
|   | 17 Fa           | ther's Name (First, Middle, La  |  | Dere   | ense Analy   | 18. Mother's Name    |                                  |                               | veriment  |
| Be  |                 | ncent James Ji  |  |  |  |                      | Norma S                          |                               |   |
| 2   |                 | nformant's Name/Relationship  |  | 19b Ma   | iling Address (Street  |                      |                                  | City or Town, State, 2        | Zin Code)   |
| 70  |                 | ncent Joseph J  |  | - 1  | -  |                      |                                  | cLean, Virg                   |   |
|   | -               | lethod of Disposition   | roradio /                                      | 20b. Place of Dis  | position (Name of  |                      | ***                              | 20c. Location - City or       |   |
|   |                 | ☐ Burial 2 X Cremation 3<br>☐ Donation 5 ☐ Other (Spec                |  | 9  | ematory or other place. Crematorium  | Decem                | ber 24,                          | Bethesda,                     | Maryland  |
|   |                 | gnature of Funery Service   |  |  |  |                      |                                  |                               |   |
| any injury or of  |                 | Magalet & Bu  | ment 1   | 101303   | 00 West Mont   | gomery Aver          | me, Rockvi                       | ockville, In<br>ille, Marylan | c.<br>d 20850-2805                                |
|   | 23a.            | Part1. Enter the disease, or co<br>shock, or heart failure. List on   | mplications that cause<br>by one cause on each | ed the death. Do not e<br>line.                                | enter the mode of dyin   | ng, such as cardiac  | or respiratory arre              | est,                          | Approximate<br>Interval Between                   |
| ian   | disea           | diate Cause (Final se or condition                                    | Venlafaxi                                      | ine Intoxicat  | ion  |                      |                                  |                               | Onset and Death                                   |
| eal<br>ner  | result          | ing in death)   | a  | s a consequence of):   |  |                      |                                  |                               |   |
| •   | Sequ            | entially list conditions,<br>leading to immediate                     | b  |  |  |                      |                                  |                               |   |
| in e  | if any          | , leading to immediate<br>b. Enter Underlying<br>a (Disease or injury | Due to (or a                                   | s a consequence of):   |  |                      |                                  |                               |   |
| Examiner  | that in         | itiated events<br>ing in death) Last                                  | C. Due to (or a                                | s a consequence of):   |  |                      |                                  |                               |   |
|   |                 |   | DUB 10 (01 a                                   | s a consequence or).   |  |                      |                                  |                               |   |
| dicai Examin  |                 |   | d  |  |  |                      | <del></del>                      |                               |   |
| Physiclan/Me  |                 | MALE:   | 23c. It yes, outcom                            | e of pregnancy   |  |                      |                                  | 004 Barrat da                 |   |
| clan/Med  | 1               | Was decedent pregnant n the past 12 months?                           | 1☐Live birth                                   | 2 Fetal death  | B Ectopic pregnance Control of the c | У                    |                                  | 23d. Date of de<br>Month      | Day Year  |
| ysic  |                 | I □ Yes 2 □ No<br>9 □ Unknown   | 9□ Unknown                                     | at time of death   | OLI Other (specily) _  |                      |                                  |                               |   |
|   | Part II         | Other significant conditions  | contributing to death                          | but not resulting in the                                       | underlying cause giv   | en in Part I.        | 23e. Did tob                     | pacco use contribute to       | the cause of death?                               |
| leted by  |                 |   |  |  |  |                      | 1 ☐ Ye                           | s 2 No 3 P                    | robably 4 Unknow                                  |
| ete   |                 |   |  |  |  |                      | 24a. Was ar                      | 24h Wara au                   | stoney findings availab                           |
| 0   | ·               |   |  |  |  |                      | autops:                          | y prior to death?             | utopsy findings availab<br>completion of cause of |
| ပိ  |                 | lan ages referred to mortical   | 4  |  |  |                      | 1 ☐ Yes 2                        | P□No 1□Yes                    | 2 □ No  |
| (C)   | 9               | as case referred to medical<br>aminer?<br>∑Yes 2□No                   | Hospital:                                      | tient 2 ☐ ER/Outoat  | 0T PO4 Ott   |                      | th (Check only one               | e)<br>ince 6 Other (Spe       | SCENE   |
| 5   | 1000            | anner of Death  | 1 ☐ Inpai                                      |  | IBRIL 3 DOA  | 4 Linursing no       |                                  | ow injury occurred            | city) COLLITE                                     |
| ţ   | 1 2             | □Natural 5 □ Pending<br>□ Accident investigat                         |  | jury 28b. Time<br>lay Year) <b>Fnd</b> Injury<br><b>3:45</b> F |  |                      |                                  | gested drugs                  |   |
| fica  | 3               | Suicide 6 Could not   | 12/10/05                                       | njury - At home, farm, etc. (Specify)                          |  | Λ                    | 28t Location (St                 | reet and Number or B          | ural Route Number                                 |
| Certification:  | 4               | ☐ Hornicide determine   |  | _  |  |                      | Apt 101 R                        | Rockville, Monr               | oe Street   |
| 0   |                 | Certifier 1 Certifying  | Physician: To the bes                          | <b>d in residenc</b><br>at of my knowledge, de                 | ath occurred at the ti   | me, date and place,  | and due to the ca                | ause(s) and manner a          | s stated.   |
| (0)   |                 | (Check only 2X Medical Ex one)  | aminer: On the basis<br>and manner:            | of examination and/or stated.                                  | investigation, in my   | opinion, death occur | red at the time, da              | ate and place, and due        | e to the cause(s)                                 |
| dica  |                 | Signature and title of certifier                                      |  |  | 29c. Licens  | se number            | 29                               | 9d. Date signed (Mont         | th, Day, Year)                                    |
| Medical   | 29b.            | 1   |  |  |  |                      |                                  |                               |   |
| Medica  | 29b.            | 1/11/11   | 17:0   |  |  | O.C.M.E.             | D                                | ecember 19                    | , 2005  |
|   |                 | Theolin Mame and address of person with                               | no completed caus                              | death (Item 23a) (Typ  |  | O.C.M.E.             | D                                | ecember 19                    | , 2005  |
| completely filled in by the tr  |                 | Theolin M   | no completed caus to                           | death (Item 23a) (Typ  | e, Print)  |                      | l                                | ecember 19<br>-<br>ryland 212 |   |

|                   |  |                | For<br>State<br>Registrar   | State  | of Maryla                      | nd / Depa                   | artmen<br>tificate       |                         |                      | and Me      |  | giene<br>Reg. Wo. | 005                  | en D                            | 152                      | 2        |
|-------------------|--|----------------|---|--|--------------------------------|-----------------------------|--------------------------|-------------------------|----------------------|-------------|--|-------------------|----------------------|---------------------------------|--------------------------|----------|
| ı                 | Physicia   | an             | 1. Decedent's Name (First, Middle   | , Last)  |                                |                             |                          |                         |                      |             | 2. Date of De.<br>Month<br>Decembe       | Day               | Yes                  | ar                              | Time of De               |          |
|                   | /Medic   |                | Mary A. Kappes  4a. Facility Name (If not institution,                              | give street and no                               | umber)                         |                             | 4b. City,                | Town, or                | Location of          |             | Decembi                                  |                   | ounty of D           |                                 | 4:00                     | <u>a</u> |
|                   | LAdillii   | Ç I            | 1032 Barrymore  | -  |                                |                             | Ве                       | l Ai                    | r                    |             |  | На                | rford                | l                               |                          |          |
|                   | Funeral<br>Director  |                | 5. Social Security Number 213-26-3834   | 6. Sex<br>1 ☐ M 2 ☐ F                            | 7. Age (In yr. 77              | s. last birthday)<br>Yrs.   | If Under<br>Months       | 1 Year<br>Days          | If Under a           | Min.        | 8. Date of Bird<br>(Month, Da<br>June 28 | y, Year)          |                      | Birthplace<br>Country)<br>aryla | (State or F              | oreign   |
|                   | pur *  |                | Usual Residence of Decedent  10a, State 10b, County                                 |  | 100.0                          | City, Town or Lo            | cation                   |                         |                      |             |  |                   |                      | 10d I                           | nside City I             | Limite   |
|                   | 72 hours after death with the Maryland<br>natural', or Items 23s or 28s-f show<br>Jicsi Evaniret must be notitied at   | ŏ              | Md. Harf  | ord  | 100.                           | ony, comit of Lo            | Bel                      | Air                     |                      |             |  |                   |                      |                                 | l ∐Yes 2⊀                |          |
|                   | the 1  | Director       | 10e. Street and Number  |  | 1                              |                             | 10f. Zip                 |                         |                      |             |  | 10g. Citiz        | en of What           | Country?                        |                          |          |
|                   | h with   | a D            | 1032 Barrymore  | Drive  |                                |                             |                          | 2                       | 21014                |             |  | U.S               | . A.                 |                                 |                          |          |
|                   | ems a  | Funeral        | 11. Marital Status  |  | cedent Ever in                 | U.S. 13.                    | Was Deced                | lent of Hi              | spanic Orig          | gin? (Spec  | cify Yes or No<br>Rican, etc.)           | - 1               | 4. Race - A          | merican Ir<br>/hite, etc.       | ndian,                   |          |
| 9                 | or It  | by Fu          | 1 □ Never Married 2 ☑ Marri   | ed 1 □ Yes<br>If Yes, G                          | 2 <del>∏</del> No<br>live      | 3                           | 1 □ Yes                  |                         | Specify:             |             | ,  | 1                 | Specify: 1           |                                 | <u>.</u>                 |          |
| 2-003p            | hour<br>tural  |                | 3 ☐ Widowed 4 ☐ Divorced  | Year or  | Dates:                         | 16a Dece                    | dent's Lieus             | I Occupa                | ation                |             |  | 16h Kin           | d of Busine          | es/Industr                      |                          |          |
| Ċ                 | in 72<br>n "na   | Completed      | (Specify only highes  | t grade completed                                |                                | 16a. Dece<br>(Give<br>life. | kind of wor<br>DO NOT us | k done a<br>se retired, | during most          | t of workin | g  | 100. 111          | a or basine          | 733/11GU3(I                     | у                        |          |
| 1212              | d with<br>giene<br>ar tha  | mo             | Elementary/Secondary (0-12)  8 years  | College  | (1-4or 5+)                     | home                        | emaker                   | <u> </u>                |                      |             |  |                   | own h                | ome                             |                          |          |
| 2                 | 12 should be filed within 72 hours after death with the Marylan<br>h and Mental Hygiene.<br>7 Ia marked other than "natural", or Items 23a or 28a-f show<br>traumatic event, the Medical Evaninating the notified at | Bec            | 17. Father's Name (First, Middle, I   |  |                                |                             |                          |                         |                      |             | (First, Middle,                          |                   | Sumame)              |                                 |                          |          |
| Maryland          | Ment<br>Ment<br>marked   | 2              | Ignatius Kuchar   |  |                                |                             |                          |                         |                      |             | stkowsk                                  |                   |                      |                                 |                          |          |
| Za<br>Za          | 12 sh<br>h and<br>7 la m<br>traum  |                | 19a. Informant's Name/Relationsh  |  |                                |                             | 3                        | •                       |                      |             | Route Number                             |                   |                      | . ,                             | de)                      |          |
| ص<br>ص            | 1 and<br>Health<br>em 2  |                | Paul DeFlavis/d   | laughter   | 20b                            | . Place of Dispo            | sition (Nan              | ne of                   |                      |             | ingdon,                                  |                   | 2100<br>ation - City |                                 | State                    |          |
| <u></u>           | ages<br>int of<br>t: If it<br>y or o   |                | 1 ☐ Burial 2 ☑ Cremation  4 ☐ Donation 5 ☐ Other (Sp                                |  | n State                        | cemetery, cřel<br>ayview (  | natory`or o              | ther place              |                      | 2/24/       | /05                                      |                   | imore                |                                 |                          |          |
| altimore,         | permit. Pages 1 and 2 should be<br>Department of Health and Menta<br>Important: If Item 27 Is marked<br>any injury or other traumatic ex   | 1              | 21. Signature of uneral Service   |  | 120                            | 2                           | 2. Name an               | d Addres                | s of Facilit         | tv          |  |                   |                      |                                 |                          |          |
| ñ                 | Den<br>Imp   | . (5           | All The   | 7  |                                |                             |                          |                         |                      |             | Home of                                  |                   |                      |                                 |                          |          |
| ı                 |  |                | 23a. Part1. Enter the disease, or shock, or heart failure. List                     | complications that                               | caused the de                  | eath. Do not en             | er the mod               | e of dying              | g, such as           | cardiac or  | respiratory a                            | rrest,            | <del>, 110 .</del>   | 11116                           | proximate<br>erval Betwe |          |
|                   | Fnysician:   |                | Immediate Cause (Final disease or condition   |  | h.                             | NO ST                       | OFE                      | Der                     | iont                 | 5 A         |  |                   |                      |                                 | set and Dea              |          |
|                   | /Medical<br>Examiner   |                | resulting in death)   | Due to   | o (or as a cons                | equence of):                |                          |                         |                      |             |  |                   |                      |                                 | 1                        |          |
|                   | LXammer  | <u>.</u>       | Sequentially list conditions,   | b. Due to  | o (or as a cons                | equence of:                 |                          |                         |                      |             |  |                   |                      | -                               |                          |          |
| $\overline{\ \ }$ | ted<br>nslt  | Examiner       | Sequentially list conditions, if any, leading to immediate Cause (Disease or injury | D00 (  | 7 (01 43 4 00113               | equence on.                 |                          |                         |                      |             |  |                   |                      |                                 |                          |          |
| v                 | be executed<br>ician and<br>burial-transit   | Exal           | that initiated events<br>resulting in death) Last                                   | c<br>Due to                                      | o (or as a cons                | equence of):                |                          |                         |                      |             |  |                   |                      |                                 |                          |          |
| 8/60,             |  | dical          |   | d  |                                |                             |                          |                         |                      |             |  |                   |                      |                                 |                          |          |
| ٥                 | The law requires that the death certificate be executed tite has been signed by the attending physician and bage 2 should be detached for use as the burial-transit  |                | IF FEMALE:  |  |                                |                             |                          |                         |                      |             |  |                   |                      |                                 |                          | _        |
| ROX               | ath ce   | Physician/Me   | 23b. Was decedent pregnant in the past 12 months?                                   | 1 Live   | utcome of preg<br>birth 2 ☐ Fe | etal death 3                | Ectopic pr               |                         |                      |             |  | 2                 | 3d. Date of<br>Month | delivery<br>Day                 | y Yea                    | ar       |
|                   | he de<br>the a   | ysic           | 1 ☐ Yes 2 ☑ No<br>9 ☐ Unknown   | 4∐Pre  | gnant at time o<br>nown        | fdeath 5L                   | Other (sp                | ecity)                  |                      |             |  |                   |                      | ŕ                               |                          |          |
| <u> </u>          | res that the de<br>signed by the a<br>be detached t  |                | Part II. Dther significant condition  | ns contributing to                               | death but not r                | esulting in the u           | nderlying c              | ause give               | en in Part I.        |             | 23e. Did t                               | obacco us         | se contribut         | e to the ca                     | ause of dea              | ith?     |
| ecords,           | w requires<br>been sign<br>should be   | ed by          |   |  |                                |                             |                          |                         |                      |             | 1 🗆                                      | Yes 2             | JNo 3□               | ] Probably                      | _4 □Unk                  | known    |
| 000               | aw rei<br>is bee<br>2 sho  | Completed      |   |  |                                |                             |                          |                         |                      |             | 24a. Was                                 |                   | 24b. Were            | autopsy 1                       | findings ava             | ailable  |
| Ĭ                 |  | Com            |   |  |                                |                             |                          |                         |                      |             | autor<br>perfo                           | rmed?             | death                | h?                              |                          | 36 01    |
| Vital H           | nysiclan:<br>nis certifica<br>director,  | Be (           | 25. Was case referred to medical examiner?  |  |                                |                             |                          |                         |                      |             | (Check only o                            |                   |                      |                                 |                          |          |
| 6                 | Physic<br>this c   | 2              | 1 ☐ Yes 2 No  |  |                                | ER/Outpatie                 |                          |                         |                      |             | ne 5 Nesi                                |                   |                      | Specify)                        |                          |          |
| ב                 | ding F<br>h.<br>After<br>funer   | lon            | 27. Manner of Death  1 Natural 5 □ Pendin 2 □ Accident investig                     | g (Mo  | e of Injury<br>onth, Day Year) | 28b. Time of<br>Injury      | M                        | 8c. Injury<br>Work      | /at<br>k?<br>Yes 2.□ |             | 8d. Describe                             | now injury        | occurred             |                                 |                          |          |
| Division          | Attendi  | fica           | 3 ☐ Suicide 6 ☐ Could i   | not be 28e. Pla                                  | ce of Injury - At              | t home, farm, st            |                          |                         |                      |             | 8f. Location (                           | Street and        | l Number o           | r Rural Ro                      | ute Numbe                | er,      |
| S                 | al or safter   | Certification; | 4 Homicide  | buil   | ding, etc. (Spe                | cify)                       |                          |                         |                      |             | City or To                               | wn, State)        |                      |                                 |                          |          |
|                   | To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.  | edical (       |   | g Physician: To to<br>Examiner: On the<br>and ma |                                |                             |                          |                         |                      |             |  |                   |                      |                                 |                          |          |
|                   | To th<br>withir<br>To th<br>compl  | Me             | 29b. Signature and title of certifie  |  |                                |                             |                          |                         | e number             |             |  |                   | signed (M            |                                 |                          |          |
| •                 |  |                | 1 ans   | he M   | 0                              |                             |                          | ) 3                     | 988                  | -9          |  | Du                | .20                  | 200                             | , 2_                     |          |
|                   | 6  |                | 30. Name and address of person  | who completed ca                                 | use of death (I                | tem 23a) (Type,             | Drint)                   |                         |                      |             |  |                   |                      |                                 |                          |          |
|                   | Sta  |                | 31. Date filed (Month, Day, Year)   | 32.  | negistrar s Sig                | mature                      |                          |                         |                      |             |  |                   |                      |                                 |                          |          |
|                   | Regist   | al             | REA   | 2 3 2005   | 1 Posica                       | 1 1%                        | Constant                 |                         |                      |             |  |                   |                      |                                 |                          |          |

|                     |  |                               | 1 - For<br>State<br>Ragistrar  | State of Ma   | aryland            |                                 | artment of<br>rtificate o            |                                 |                                 |  | iene                             | 5                                  | 41523   |
|---------------------|--|-------------------------------|--|---|--------------------|---------------------------------|--------------------------------------|---------------------------------|---------------------------------|--|----------------------------------|------------------------------------|---|
|                     |  |                               | 1. Decedent's Name (First, Middle, Last)   |   |                    |                                 |                                      |                                 | 2                               | 2. Date of Dea<br>Month                    | th                               | Vere                               | 3. Time of Death                              |
|                     | Physici<br>/Medid  |                               | PEGGY  | K   | ILE                |                                 |                                      |                                 |                                 |  | R 18, 2                          | Yeer<br>005                        | 4:55 A. M.                                    |
|                     | Examin   |                               | 4a. Facility Name (If not institution, give  |   |                    |                                 | 4b. City, Town                       |                                 |                                 |  | 4c. County                       |                                    |   |
|                     |  |                               | FOREST HILL HEALT  |   |                    |                                 | If Under 1 Ye                        | OREST                           |                                 |  |                                  | HARFO                              |   |
|                     | Funeral  |                               | 5. Social Security Number 6. Security Number 1   | IM 2 TE   | ə (in yrs. ia<br>4 | ast birthday)<br>Yrs.           | Months Da                            |                                 | Min.                            | B. Date of Birth<br>(Month, Day<br>Oct. 25 | Year)<br>1951                    | 9. Birth                           | place (State or Foreign<br>intry)<br>'Y Land  |
|                     | Director   |                               | 215-64-3222 Usuel Residence of Decedent  | х   | 4                  |                                 | l                                    |                                 |                                 | JCL - 23                                   | , 1901                           | nai                                | yrand   |
|                     | yland<br>yland   |                               | 10a. State 10b. County   |   | 10c. City          | , Town or Lo                    |                                      |                                 |                                 |  |                                  |                                    | 10d. Inside City Limits                       |
|                     | e Mar  | ctor                          | Md. Baltimo  | re  |                    |                                 | Balt                                 | imore                           |                                 |  |                                  |                                    | 1 DYes 2 No                                   |
|                     | or 28  | Dire                          | 10e. Street and Number   |   |                    |                                 | 10f. Zip Cod                         |                                 |                                 | 1  | 0g. Citizen of                   |                                    | intry?  |
|                     | ath w  | ral                           | 48 Jumpers Circle  |   |                    |                                 | 1                                    | 21236                           |                                 |  | U.S.A                            |                                    |   |
|                     | ltems  | nue                           | The state of the s | 12. Was Decedent I<br>Armed Forces?                         |                    | S. 13. \                        | Was Decedent of<br>f Yes, specify C  | of Hispanic C<br>Juban, Mexic   | origin? (Speci<br>an, Puerto Ri | ify Yes or No-<br>can, etc.)               |                                  | ce - Ameri<br>ck, White,           | ican Indian,<br>, etc.                        |
| 36                  | irs aft  | by F                          | 1 Never Married 2 Married 3 Widowed 4 Divorced   | 1 □XYes 2 □ N<br>If Yes, Give<br>Year or Dates:             | 40                 |                                 | 1☐Yes 2€1                            | No Specifi                      | y:                              |  | Specif                           | y: wh                              | nite  |
| 9                   | within 72 hours after death with the Maryland<br>ene.<br>then *netural', or Items 23e or 28e-f show<br>the Medical Examiner must be motified at  | Completed by Funeral Director | 15. Decedent's Edu   |   |                    | 16a. Deced                      | ient's Usual Oc                      | cupation                        |                                 |  | 16b. Kind of B                   | usiness/Ir                         | ndustry                                       |
| 215                 | thin 7<br>9.   | ple                           | (Specify only highest grade<br>Elementary/Secondary (0-12)   | College (1-4or 5  | i+)                | life.                           | kind of work do<br>DO NOT use rei    | ne aunng m<br>tired)            | ost of working                  | ,  |                                  |                                    |   |
| 21                  | ed wi  | 5                             | 12 years   |   |                    | Offic                           | e clerk                              |                                 |                                 |  | state                            |                                    | ce  |
| Ind                 | 2 should be filed within 72 hours after death with the Marylan and Mental Hygiene. Is marked other than "natural", or Items 23a or 28a-f show sumatic event, the Medical Examinations to contined at | Be                            | 17. Father's Name (First, Middle, Last)  |   |                    |                                 |                                      |                                 |                                 |  | Maiden Suman                     | ne)                                |   |
| <u>ya</u>           | Men<br>Marke<br>Marke  | 5                             | Henry Jones  | 0.14  |                    | 101 11 11                       |                                      |                                 |                                 | (Unknow                                    |                                  |                                    |   |
| Maryland 21215-0036 | d 2 sh<br>th and<br>7 ts r<br>traun  |                               | 19a. Informant's Name/Relationship (Ty<br>Robert L. Kile   | pe, Printj  |                    |                                 | ng Address (Straumpers               |                                 |                                 |  |                                  |                                    | o Code)                                       |
| <u>ق</u>            | s 1 and 2 should<br>f Health and Men<br>item 27 is marke<br>other traumatic  |                               | 20a. Method of Disposition   |   | 20b. PI            | ace of Dispo                    | sition (Name of                      |                                 | Dat                             |  | 20c. Location                    |                                    | own, State                                    |
| JOIL<br>I           | ages<br>ant of<br>it: If it  |                               | 1 Burial 2 Cremation 3 F<br>4 Donation 5 Other (Specify)   | lemoval from State  |                    | -                               | natory`or other ;<br>Cremato         | . 1                             | 12/19/                          |  | Baltime                          |                                    |   |
| Baltimore,          | permit. Pages 1 and 2<br>Department of Health a<br>Important: If item 27 ts<br>any injury or other tra   |                               | 21. Signature of Fundamental   | 3   | , Da               |                                 | Name and Ad                          |                                 |                                 |  |                                  |                                    |   |
| ñ                   | permi<br>Depart<br>Impo<br>any ir  |                               | ) All  | 9   |                    |                                 | chimune<br>10 W. M                   |                                 |                                 |  |                                  |                                    |   |
|                     |  |                               | 23a. Part1. Enter the disease, or complishock, or heart failure. List only of  | ications that caused  | the death          |                                 |                                      |                                 |                                 |  |                                  | 442                                | Approximate<br>Interval Between               |
|                     | Physician  |                               | Immediate Cause (Final disease or condition  | 011   | 1                  |                                 | den                                  | 6.                              |                                 |  |                                  |                                    | Onset and Death                               |
|                     | /Medical   |                               | resulting in death)  | Due to (or as   | consequ            |                                 |                                      |                                 |                                 |  |                                  |                                    |   |
|                     | Examiner   | L                             | Sequentially list conditions,  | b   |                    |                                 |                                      |                                 |                                 |  |                                  |                                    |   |
| J                   | ed<br>isit   | ine                           | if any, leading to immediate cause. Enter Underlying   | Due to (or as   | a consequ          | ience of):                      |                                      |                                 |                                 |  |                                  |                                    |   |
| Ň                   | and and II-tran  | Examiner                      | that initiated events resulting in death) Last   | Due to (or as   | a consequ          | ience of):                      |                                      |                                 |                                 | _  |                                  | -                                  |   |
| 8760,               | death certificate be executed<br>e attending physician and<br>of for use as the burial-transit   | dicalE                        |  |   |                    |                                 |                                      |                                 |                                 |  |                                  |                                    |   |
| 89                  | ificate<br>g phy<br>as the   | edic                          |  | 1.  |                    |                                 |                                      |                                 |                                 |  |                                  |                                    |   |
| Вох                 | eath certific<br>attending p   | M/u                           | IF FEMALE: 23b. Was decedent pregnant  | 3c. If yes, outcome<br>1 ☐ Live birth                       |                    |                                 | Ectopic pregna                       | 50.                             |                                 |  | 23d. Da                          | te of deliv                        | ery   |
|                     | the att  | Physician/Me                  | in the past 12 months? 1 Yes 2 No  | 4☐Pregnant at   |                    |                                 | Other (specify,                      |                                 |                                 |  | Mo                               | onth                               | Day Year                                      |
| P.0                 | <b>⇒</b> > ○   | Phy                           | 9 Unknown  |   |                    |                                 |                                      |                                 |                                 |  |                                  |                                    |   |
| js,                 | 89 69  | by                            | Part II. Other significant conditions cor  | ithouting to death of                                       | ut not resu        | iiting in the ui                | nderlying cause                      | given in Par                    | t I.                            |  | oacco use cont<br>es 2□No        |                                    | the cause of death?                           |
| Records,            | w requir<br>been si<br>should  | Completed                     |  |   |                    |                                 |                                      |                                 |                                 |  |                                  |                                    |   |
| 3ec                 | e la<br>has  | шp                            |  |   |                    |                                 |                                      |                                 |                                 | 24a. Was a autops perform                  | iv l                             | Were auto<br>prior to co<br>death? | opsy findings available ompletion of cause of |
|                     |  | e Co                          | 35 Was anno referred to medical  |   |                    |                                 |                                      |                                 |                                 | 1 Yes                                      | 2Q No                            | 1 🗆 Yes 🔪                          | <b>₹</b> □ Nο                                 |
| Vital               |  | 00                            | 25. Was case referred to medical examiner?  1 Yes No   | lospital:<br>1 ☐ Inpatie                                    | nt 2 🗆 1           | ER/Outpatien                    | t 3 DOA                              | O.1.                            |                                 | Check only on                              | e)<br>ence 6 □Oth                | or (Casai                          | 4.0   |
| o                   | y Phys<br>er this  | n; To                         | 27 Manner of Death   | 28a. Date of Injur  | ry                 | 28b. Time of                    | 28c. Ir                              | njury at                        |                                 |  | w injury occur                   |                                    | <i>y)</i>                                     |
| ion                 | Attending r death. sctor: After y the fune   | atio                          | 1 Natural 5 Pending 2 Accident investigation   | (Month, Day   | ( Tear)            | Injury                          |                                      | Vork?<br>□Yes 2[                | □No                             |  |                                  |                                    |   |
| Division            | er de<br>recto   | Certification;                | 3 Suicide 6 Could not be 4 Homicide determined   | 28e. Place of Inju-<br>building, etc                        | ury - At hou       | me, farm, str                   | eet, factory, office                 | се                              | 28                              | f. Location (St<br>City or Town            |                                  | er or Rura                         | al Route Number,                              |
|                     | ital o<br>rrs aft<br>ral Di<br>led in  |                               |  |   |                    |                                 |                                      |                                 | 1                               |  |                                  |                                    |   |
|                     | To the Hospital or Attending Ph<br>within 24 hours after death.<br>To the Funeral Director: After th<br>completely filled in by the funeral  | edical                        | 29a. Certifier (Check only one)  1 Certifying Physical Certifician Ph | sicien: To the best oner: On the basis of<br>and manner sta | examinati          | vledge, death<br>ion and/or inv | occurred at the<br>restigation, in m | e time, date a<br>ny opinion, d | and place, and<br>eath occurred | d due to the ca<br>at the time, d          | ause(s) and ma<br>ate and place, | inner as s<br>and due to           | tated.<br>o the cause(s)                      |
|                     | o the  | Med                           | 29b. Signature and title of certifier  | and marrier sta   |                    |                                 | 29c. Lice                            | ense numbe                      | r                               | 2  | 9d. Date signe                   | d (Month,                          | Day, Year)                                    |
|                     | - s - ō  |                               | Da. 057  | `.  |                    |                                 | 0                                    | 322                             | 55                              |  | 1                                | 4                                  | 17,2005                                       |
|                     | 1  |                               | 30. Name and address of person who co  | mpleted cause of d  | eath (Item         | 23а) (Туре,                     |                                      | ,                               | - 3                             |  | JECEM                            | 13.20                              | 11,0005                                       |
|                     | Q  | -                             | DR. DAVID DUNN -   | 615 W. 1  | МАСРН              | AIL RO                          | DAD -                                | BEL A                           | IR, MD                          | . 210                                      | 14                               |                                    |   |
| •                   | Sta  |                               | 31. Date filed (Month, Day, Year) DEC 2 3 2  | 32. Registra  | ar's Signat        | ure                             | land .                               |                                 |                                 |  |                                  |                                    |   |
|                     | Registr  | ar                            | DEC 2 9 5  | LUU.  | dille .            | 15° 6                           | porti                                |                                 |                                 |  |                                  |                                    |   |

|                            |   |                               | For<br>State<br>Registrar   | State of Ma  | arylar       |                                  | artme                   | nt of H             |                               | and M              |   | jiene ()                   | 05                             | 41524  |
|----------------------------|---|-------------------------------|---|--|--------------|----------------------------------|-------------------------|---------------------|-------------------------------|--------------------|---|----------------------------|--------------------------------|--|
| ė.                         |   |                               | 1. Decedent's Name (First, Middle, Li   | ast)   |              |                                  |                         |                     |                               |                    | 2. Date of Dea<br>Month                     | th<br>Day                  | Year                           | 3. Time of Death                               |
|                            | Physici<br>/Medi  |                               | William Koelker   |  |              |                                  |                         |                     |                               |                    | 12  |                            | 1005                           | 7:42 AM  |
|                            | Examir  | ner                           | 4a. Facility Name (If not institution, gi   |  | `,           | 4                                | -                       |                     | r Location o                  |                    |   |                            | unty of Death                  |  |
| 4                          |   | 7                             | - 10.17 7   | IRT HOS  |              |                                  |                         | um D<br>er 1 Year   | If Under                      |                    |   |                            | LEG                            |  |
|                            | Funeral<br>Director   |                               |   | Sex 7. Ag  | 68           | last birthday)<br>Yrs.           | Month                   |                     | Hours                         | Min.               | 8. Date of Birth<br>(Month, Day)<br>Oct 24, | Year)                      | Cour                           | place (State or Foreign<br>http)<br>yland      |
|                            | ow ow   |                               | 10a. State 10b. County  |  | 10c. Cit     | y, Town or Lo                    | ocation                 |                     |                               |                    |   |                            | 1                              | 0d. Inside City Limits                         |
|                            | Many<br>Pert ah   | ó                             | MD Allega   | ıny  | C            | umber1                           | and                     |                     |                               |                    |   |                            |                                | 1 ☐ Yes 2√ No                                  |
|                            | or 28   | ire                           | 10e. Street and Number  |  |              |                                  | 10f. 2                  | ip Code             |                               |                    | 1   | 0g. Citizen                | of What Cour                   | ntry?  |
|                            | 23a c   | ai                            | 14101 Winchester  | Road Lot   | M            |                                  |                         |                     | 21502                         |                    |   |                            | USA                            |  |
|                            | tems<br>from  | Tue                           | 11. Marital Status  | 12. Was Decedent<br>Armed Forces?                              |              | .S. 13.                          | Was Dec                 | edent of H          | ispanic Origin, Mexican       | gin? (Spec         | cify Yes or No-<br>Rican, etc.)             |                            | Race - Americ<br>Black, White, |  |
| 36                         | s afte  | Ž.                            | 1 ☐ Never Married 2 ☑ Marned<br>3 ☐ Widowed 4 ☐ Divorced  | 1 MYes 2 ☐ I<br>If Yes, Give<br>Year or Dates:                 |              |                                  |                         | 2 No                | Specify:                      |                    |   |                            |                                | ite  |
| 21215-0036                 | 72 hours after death with the Maryland<br>naturel', or items 23a or 28a-f ahow<br>disal Examinar must be recitied at  | Completed by Funeral Director | 15. Decedent's E  |  | <b>'</b> 57- | -61<br>16a. Dece                 | dent's LIs              | ual Occup           | ation                         |                    |   | 16h Kind o                 | of Business/Inc                |  |
| 212                        | nin 72  | piet                          | (Specify only highest gi Elementary/Secondary (0-12)  | ade completed)  College (1-4or 5                               |              | (Give                            | kind of v               |                     | during most                   | t of workin        | 9   | TOD. TUITO                 | ) Dusiness/III                 | Justry   |
| 217                        | d within<br>giene.  | Ĕ                             | 10  | 0  | ) T)         | tr                               | ruck                    | drive               | er                            |                    |   | tran                       | sporta                         | tion   |
| pu                         | be filed<br>ntal Hygis<br>ad other<br>event,  | Be (                          | 17. Father's Name (First, Middle, Las   | 1)   |              |                                  |                         |                     | 18. Mothe                     | r's Name           | (First, Middle, I                           |                            |                                |  |
| yla                        | should to   | 2                             | William Joseph  |  |              |                                  |                         |                     |                               |                    | Elizab                                      |                            |                                |  |
| Maryland                   | 2 sh<br>and<br>is m   | 1                             | 19a. Informant's Name/Relationship  |  |              |                                  |                         |                     |                               |                    | Route Number                                |                            |                                |  |
|                            | 1 and<br>Health<br>Iem 27<br>other to   |                               | Sandra Koelker  | spouse   | 20h F        | 1410<br>Place of Dispo           |                         |                     | ster I                        |                    | -   |                            |                                | MD 21502                                       |
| Baltimore,                 | Peges<br>nent of<br>int: If it  |                               | 1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☑ Donation 5 ☐ Other (Special Control of Cont | (y) /  |              | emetery, crei                    |                         |                     | (e)                           |                    | 10  | 20c. Locati                | on - City or To                | wn, State                                      |
| Balt                       | permit. Depertuimporta  |                               | 21. Sonature of Funeral Service Lice<br>Renald S.   | Wade, pir  | ecto         | r   S1                           | tate                    | Anato               | ss of Facility<br>Omy B<br>MD | y<br>oard<br>21201 | 655 W.                                      | balti                      | imore S                        | treet  |
|                            | 38.   |                               | 23a. Part 1. Enter the disease, or con<br>shock, or heart failure. List only  | plications that caused<br>one cause on each li                 | the deat     | h. Do not ent                    | ter the mo              | ode of dyin         | g, such as                    | cardiac or         | respiratory arre                            | est,                       |                                | Approximate<br>Interval Between                |
| 1                          | Physician   |                               | Immediate Cause (Final disease or condition   | GN3.   | 57           | AGE                              | RE                      | CPT                 | RATO                          | RY                 | EA.   | TLUR                       | <u>_</u>                       | Onset and Death                                |
| <i>[</i>                   | /Medical<br>Examiner  |                               | resulting in death)   | Due to (or as  |              |                                  | -,,-                    | 2512                | 10,110                        | , ,                |   |                            |                                |  |
| Ä                          | LAGITATE  |                               | Sequentially list conditions.   | b. LUNG  |              | LANCE                            | R.                      |                     |                               |                    |   |                            |                                |  |
|                            | led<br>Isit   | nlne                          | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury   | Due to (or as  | a conseq     | uence or):                       |                         |                     |                               |                    |   |                            |                                |  |
| 6                          | al-trai   | Examiner                      | that initiated events resulting in death) Last  | c<br>Due to (or as   | a conseq     | uence of):                       |                         |                     |                               |                    |   |                            |                                |  |
| 8760,                      | cate be executed<br>chysicien and<br>the burial-transit   | cal                           | (   | d  |              |                                  |                         |                     |                               |                    |   |                            |                                |  |
| 9                          | tificat<br>ig phy<br>as th  | led                           |   | •  |              |                                  |                         |                     |                               |                    |   |                            |                                |  |
| Вох                        | ettending p   | an/N                          | IF FEMALE:<br>23b. Was decedent pregnant  | 23c. If yes, outcome<br>1□Live birth                           |              |                                  | Tectonic                | pregnancy           |                               |                    |   | 23d.                       | Date of delive                 | ry   |
| о<br>Ш                     | Attending Physician: The law requires that the deeth certificate be executed rideath.  ector: After this certificate hes been signed by the ettending physicien and by the funeral director, page 2 should be detached for use as the burial-transit. | Physician/Med                 | in the past 12 months? 1 Yes 2 No 9 Unknown   | 4☐Pregnant at<br>9☐Unknown                                     |              |                                  | Other (s                |                     |                               |                    |   |                            | Month                          | Day Year                                       |
| P.O.                       | ires that the de<br>signed by the e<br>I be detached f  | Ph)                           | Part II. Other significant conditions   | contributing to death b  | ut not res   | ulting in the u                  | nderhing                | Cauco aive          | on in Part I                  |                    | 23e Did tob                                 | 2000 1100 0                | ontohuta ta th                 | e cause of death?                              |
| ds,                        | signe<br>d be   | 1 by                          | HYPERTENSI  | A 1  | at 110t 103  | oiting in the di                 | Hoerlying               | Cause give          | on airan i.                   |                    |   | s 2 No                     |                                | ably 4 Unknown                                 |
| Sor                        | w require<br>been si<br>should b  | Completed                     |   | MELLTTV  | ς            |                                  |                         |                     |                               |                    |   |                            |                                |  |
| Re                         | he lav  | E G                           |   | TEILIV   |              | <del> </del>                     |                         |                     |                               |                    | 24a. Was at autops perform                  | y                          |                                | osy findings available<br>npletion of cause of |
| <u>e</u>                   | ificete   |                               | AWX IET /   |  |              |                                  |                         |                     |                               |                    | 1□ Yes 2                                    | No                         | 1 🗌 Yes                        | 2 No   |
| 5                          | /sicia<br>s cert<br>direct  | To Be                         | examiner?   | Hospital:  | nt 2         | ER/Outpatien                     | nt 3 🗆 🗆                | Othe                | 10                            |                    | (Check only one<br>e 5 ☐ Reside             |                            | Other (0 (                     |  |
| of                         | ding Physician: The Ih. h. After this certificete he funeral director, page   |                               | 27. Manner of Death   | 28a. Date of Inju  |              | 28b. Time of                     |                         | 28c. Injury<br>Work |                               |                    | d. Describe ho                              |                            |                                | "  |
| ion                        | ttending<br>death.<br>ctor: Aft<br>/ the fun  | atio                          | 1 ☐ Matural 5 ☐ Pending 2 ☐ Accident investigation  |  | / rear)      | Injury                           | м                       |                     | <br Yes 2 □ N                 | No                 |   |                            |                                |  |
| Division of Vital Records, | of or Atte  | Certification;                | 3 Suicide 6 Could not to determined   |  | ury - At ho  | ome, farm, str                   | eet, facto              | ry, office          |                               | 28                 | Bf. Location (Sti<br>City or Town           | reet and Nu<br>, State)    | mber or Rurai                  | Route Number,                                  |
|                            | To the Hospital or Attent within 24 hours effer deatl To the Funeral Director: completely filled in by the  | Medical C                     | 29a. Certifier 1 Certifying P (Check only one) 2 Medical Exe  | hysician: To the best of miner: On the basis of and manner sta | examina      | wledge, death<br>tion and/or inv | n occurre<br>vestigatio | d at the tim        | e, date and<br>pinion, deat   | d place, ar        | nd due to the ca<br>d at the time, da       | use(s) and<br>ite and plac | manner as sta                  | ated.<br>the cause(s)                          |
|                            | To the To the Comp  | Ž                             | 29b. Signature and title of certifier   |  |              |                                  | 25                      | c. License          | number                        |                    | 25  | d. Date sig                | ned (Month, L                  | Day, Year)                                     |
|                            |   |                               | TASNEEM   | MALIK  | M.           | 0                                | 13                      | 005                 | 19121                         |                    |   | 12/1                       | 8/20                           | 05   |
|                            |   |                               | 30. Name and address of person who  | completed cause of d   |              |                                  |                         |                     |                               | -                  |   |                            | ,                              |  |
|                            |   |                               | TASNEEM MALI  |  |              |                                  | VE,                     | SU:                 | ITE                           | 301                | 1 CU  | MBG                        | SLAND,                         | MD21502  |
|                            | Sta<br>Registr  |                               | 31. Date filed (Month, Day, Year)   | 32. Registra   | ars Signa    | ture                             | sall.                   |                     |                               |                    |   |                            |                                |  |

|         |  | ı  |                     | 1 - For<br>State<br>Registrar  | State o   | of Maryla                                 |  | artment<br><i>rtificate</i>      |                    |                                       | Mental Hy                                 | giene                              | ) 5                                 | 41525   |
|---------|--|--|---------------------|--|---|---|--|----------------------------------|--------------------|---------------------------------------|---|------------------------------------|-------------------------------------|---|
|         |  | Physici  |                     | 1. Decedent's Name (First, Middle, Last) Torrence A. Levens  |   |   |  |                                  |                    |                                       | 2. Date of De Month                       | Day                                | Year /)5                            | 3. Time of Death                                |
|         |  | /Medio<br>Examir   |                     | 4a. Facility Name (If not institution, give Upper Chesapeake I   | street and nu   |   | er   | 4b. City, To                     |                    | Location of De                        | ath                                       | 4c. County<br>Harf                 |                                     | 1100  |
|         |  | Funeral<br>Director  |                     | 5. Social Security Number 6. Sec   |   |   | rs. last birthday)<br>Yrs.                     | If Under 1<br>Months             | Year<br>Days       | If Under 24 Hi<br>Hours Mi            |   | th<br>19, Year)<br>1914            | 9. Birthp<br>Cour<br>Peni           | olace (State or Foreign<br>oftry)<br>onsylvania |
|         | 500                                      | yland<br>M   |                     | Usual Residence of Decedent  10a. State 10b. County  |   |   | City, Town or Le                               | ocation                          |                    |                                       |   |                                    |                                     | 0d. Inside City Limits                          |
| 8       | book of the Mood                         | 28a-f et   | rector              | Md. n/a  |   |   | Balti  | more                             | Code               |                                       |   | 10g. Citizen of                    | What Cour                           | 1 ☐Yes 2 ☐ No                                   |
| Q       | į.                                       | 38 0   | 0                   | 4612 Frankford Av  | enue  |   |  |                                  |                    |                                       |   | U.S.A.                             |                                     | •   |
| 267     | 036                                      | permit. Pages I and a should be tiled within 7.2 flours after death with the Marylan Department of Health and Mental Hygiene. Independent if them 27 is marked other than "naturel", or iteme 23a or 28a-f show any injury or other traumatic event, it a Medical Examin at most be inclined at Appea.   | by Funeral Director |  | 12. Was Dec<br>Armed Fo<br>1 ☐ Yes<br>If Yes, Gi<br>Year or D | orces?<br>2√∏No<br>ve                     |  | Was Deceder<br>If Yes, specify   |                    |                                       | (Specify Yes or No<br>arto Rican, etc.)   | 14. Rad<br>Bla<br>Specif           | ce - Americ<br>ck, White,<br>y: wh: |   |
| -       | Maryland 21215-0036                      | nunn 72 no<br>38.<br>38. "natur<br>9 Medicul   | Completed           | 15. Decedent's Edu<br>(Specify only highest grade<br>Elementary/Secondary (0-12)   | cation<br>completed)<br>College (                             | 1-4or 5+)                                 | (Give  |                                  | done d<br>retired; | ition<br>uring most of w              | vorking                                   | 16b. Kind of B                     |                                     |   |
| 0       | 22                                       | Hygier<br>Hygier<br>Ther ti  | S                   | 12 years 17. Father's Name (First, Middle, Last)   |   |   | part   | s mana                           | ger                | 19 Mather's N                         | ame (First, Middle,                       | Mack Ti                            |                                     | inc.  |
| 3/15/05 | yland                                    | Mental F<br>Marked of  | To Be               | Frank E. Levengoo  |   |   |  |                                  |                    | Jenni                                 | e Graham                                  |                                    |                                     |   |
| तः      | Mar                                      | th and 27 le m   |                     | 19a. Informant's Name/Relationship (Ty<br>Scott Levengood/s  |   |   |  |                                  |                    |                                       | Bel Air,                                  |                                    |                                     | Code)   |
|         | Baltimore,                               | ages I all<br>ant of Hea<br>nt: If Item<br>y or othe   |                     | 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)   | emoval from   | State                                     | b. Place of Dispo<br>cemetery, cre<br>Highview | matory or othe                   | er place           |                                       | Date 19/05                                | 20c. Location                      |                                     |   |
| _       | Baltin                                   | Depertment in poorter in projection in proje |                     | 21. Signature of Funeral Service Licens  | 98  |   | S  | 2. Name and .                    | Addres<br>1 e K    | Funeral                               | Home of                                   | Bel Ai                             | r, In                               | с.  |
| 327     |  | hysician   |                     | 23a. Part1. Enter the disease, or compleshock, or heart failure. List only or Immediate Cause (Final disease or condition                                    | cations that one cause on e                                   | caused the deach line.                    | eath. Do not en                                | ter the mode                     | of dying           | , such as cardi                       | load, Bel ac or respiratory as            | Air, Mo                            | 1. 21                               | Approximate Interval Between Onset and Death    |
| 1ce #0: | 8760, <                                  | hys<br>he  | dical Examiner      | Sequentially list conditions, if any, leading to infimediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last | Dua to  | (or as a cons                             | sequence of):                                  |                                  |                    |                                       |   |                                    |                                     |   |
| 2,      | The law requires that the death certific | es trial fire death centrific<br>igned by the ettending p<br>be detached for use as  | Physician/Medical   | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No   |   | oirth 2 ☐ F<br>nant at time o             | etal death 3[                                  | ∃Ectopic preg<br>∃ Other (spec   |                    |                                       |   |                                    | te of delive                        | ery<br>Day Year                                 |
| F:      | rds, P                                   | wirequires inate been signed to should be detailed.  | by                  | Part II. Other significant conditions con  | stributing to d   | eath but not                              | resulting in the u                             | inderlying cau                   | ise give           | n in Part I.                          |   |                                    |                                     | ne cause of death?<br>ably 4 Denknown           |
| ood,    |  | certificete has been<br>rector, page 2 should  | Completed           |  |   | -   |  |                                  |                    |                                       | 24a. Was<br>autor<br>perfo<br>1 ☐ Yes     | rmed?                              | Were autoperior to condeath?        | psy findings available appletion of cause of    |
| 0       | of Vita                                  | certif   | Be C                | 25. Was case referred to medical examiner?   | lospital:   |   | /  |                                  | Othe               |                                       | eath Check only o                         |                                    | -                                   |   |
|         |  | After<br>After<br>funei  | tion: To            | 27. Manne of Death  1 Natural 5 Pending 2 Accident investigation   |   | Inpatient 2<br>of Injury<br>oth, Day Year | 28b. Time o<br>Injury                          |                                  | . Injury<br>Work   | 4   Nursing                           | Home 5 Resid                              | dence 6 Oth                        |                                     | /)  |
| EVEN    | = 3                                      | a after death. I Director: A   | Certification:      | 3 Suicide 6 Could not be determined  | 28e. Place<br>build   | of Injury - A<br>ing, etc. (Spe           | At home, farm, st<br>ecify)                    | reet, factory, o                 | office             |                                       | 28f. Location (S<br>City or Tox           |                                    | er or Rura                          | l Route Number.                                 |
|         | e Cook                                   | within 24 hours a To the Funeral I completely filled   | edical C            | 29a. Certifier 1 Certifying Physical Control 2 Medical Examination   | ter: On the b   | e best of my<br>easis of examiner stated  | knowledge, deat                                | h occurred at<br>vestigation, in | the tim            | e, date and place<br>inion, death occ | ce, and due to the<br>curred at the time, | cause(s) and ma<br>date and place, | anner as st<br>and due to           | ated.<br>the cause(s)                           |
|         | Total                                    | withir<br>To th  | Me                  | 29b. Signature and title of certifier  | 11  |   |  |                                  |                    | number                                |   | 29d. Date signe                    |                                     |   |
|         |  | ,  |                     | <b>)</b>   | .//   |   |  | 1                                | 03                 | 50/2                                  | -   |                                    |                                     | 2 16, 2005                                      |
|         |  | 6  |                     |  | NCH   | n.  |  | Print)                           | 17                 | Z AV                                  | e. Be.                                    | Air,                               | nd.                                 | 21014.  |
|         | index<br>機構                              | Sta<br>Registr   |                     | 31. Date filed (Month, Day, Year) DEC 2 3 20   | 105 32. 5   | egistrar's Si                             | gnature  | ander                            |                    |                                       |   |                                    |                                     |   |

DHMH 17 Rev 1/2001

|  | 1- State of Maryland / Dep Registrar Ce   |   |   | 41526   |
|--|---|---|---|---|
| Physician  | 1. Decedent's Name (First, Middle, Last) Claude Charles Langston  |   | Date of Death Dec, 19ay, 2003   | 3. Time of Death                                      |
| /Medical<br>Examiner   | 4a. Facility Name (If not institution, give street and number)  Future Care Home Wood   | 4b. City, Town, or Location of Death  Baltimore   | 4c. County of De  |   |
| Funeral<br>Director  | 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 212-44-7106 ★ M 2□ F 60 Yrs.  | If Under 1 Year   If Under 24 Hrs.   Months   Days   Hours   Min.                           | 8. Date of Birth (Month, Day, Year)  June-13-1945                           | Birthplace (State or Foreign<br>Country)  Md          |
| yland  | Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or L  |   |   | 10d. Inside City Limits                               |
| the Marylan<br>28a-f show<br>notified at   | Md N/A Baltimo  |   |   | 1★Yes 2□No  |
| uth with the Maryla<br>23a or 28a-f shows<br>vst be notified at<br>rai Director  | 1600 W. Mt Royal ave Apt 608  | 10f. Zip Code 21217   | 10g. Citizen of What U.S.A.   | •   |
| urs after des  | 1 □ Never Married 2 ☐ Married 1 □ Yes 2 ☐ No If Yes, Give 3 □ Wildowed 4 □ Divorced Year or Dates:  | Was Decedent of Hispanic Origin? (Spelf Yes, specify Cuban, Mexican, Puerto                 | Specify:  | Black   |
| ed within 72 houygiene. Ner than "natura" t, Ira Mudical E   | Elementary/Secondary (U-12)   College (1-40f 5+)  | dent's Usual Occupation kind of work done during most of worki DO NOT use retired) Calesman |   | re Stores   |
| permit. Pages 1 and 2 should be tiled within Department of Health and Mental Hygiene. Important: If Item 27 is marked other than eny injury or other treumatic event, tra Mance.  To Be Compi  | 17. Father's Name (First, Middle, Last)  Lester Langston Sr.  | France  | (First, Middle, Maiden Sumame) es Hatwood                                   |   |
| d 2 sh<br>ith and<br>27 is m<br>treum  | _   | ing Address (Street and Number or Rura <b>0 W. Mt Royal</b> a                               |   |   |
| Pages 1 and of Heal of | 20a. Method of Disposition 20b. Place of Disposerior 20b. Place of Disposerior, cremetery, cre  |   | Date 20c. Location - City   | or Town, State  |
| permit. I<br>Departm<br>Importa<br>eny inju  | 21. Signature of 5 heral Service Licensee   | 2. Name and Address of Facility Cha   | tman Harris Fu  | neral Home  |
| Physician<br>/Medical<br>Examiner  | 23a. Part. Inter the disease, or complications that caused the death. Do not enshock or heart/ailure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. Due to (or as a consequence of): | 1 500 50  | or respiratory arrest,  | Approximate Interval Between Onset and Death          |
| cate be executed physicien and the burial-transit dical Examiner   | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):          |   |   |   |
| The law requires that the death certificat the has been signed by the attending phy bage 2 should be detached for use as the completed by Physician/Medit  |   | □Ectopic pregnancy □ Other (specify)  | 23d. Date of c  | deliv <b>ery</b><br>Day Year                          |
| w requires that the been signed by should be detac   | Part II. Other significant conditions contributing to death but not resulting in the  | inderlying cause given in Part I.   | 23e. Did tobacco use contribute   | to the cause of death?  Probably 4 Unknown            |
|  |   |   | autopsy prior t   | autopsy findings available o completion of cause of ? |
| Physicien: Th rhis certificate ral director, pag.; To Be Co  | 25 Was case referred to medical examiner?  1  Yes 2 No  Hospital: 1 Inpatient 2 ER/Outpatie   | 26. Place of Death  | n (Check only one)<br>me 5 ☐ Residence 6 ☐Other (Sp                         |   |
| Attending Phy or death.  ector: After this by the funeral or ification: T  | 27. Manner of Death  1 Natural 5 Pending (Month, Day Year)  2 Accident investigation  |   | 28d. Describe how injury occurred   | pecify)   |
| To the Hospitel or Attending P within 24 hours after death. To the Funerel Director: After t completely filled in by the funerat Medical Certification:  | 3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, st building, etc. (Specify)   | reet, factory, office   | 28f. Location (Street and Number or<br>City or Town, State)                 | Rural Route Number,                                   |
| the Hospit<br>in 24 hour<br>the Funer<br>pletely fills<br>edical (   | 29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, dea 2 Medical Examiner: On the basis of examination and/or in and manner stated.   | th occurred at the time, date and place, avestigation, in my opinion, death occurr          | and due to the cause(s) and manner<br>ed at the time, date and place, and d | as stated.<br>ue to the cause(s)                      |
| To the within To the company   | 29b. Signature and title of certifier   | 29c. License number   | 29d. Date signed (Mo  | nth, Day, Year)                                       |
| 2  | 30. Name and address of person who completed cause of death (Item 23a) (Type  | Print)<br>West MT Royal   | Ave Balt M  | 0 21217   |
| State<br>Registrar   | 31. Date filed (Month, Day, Year)  32. Regulara's Signature  DFC 2 3 2005   | Print)  Vest NT Rayal   |   |   |

DHMH 17 Rev 1/2001

Registrar

DFC 2 3 2005

|                   |  |                   | For<br>State<br>Registrar   |  | of Marylar  | nd / Dep<br><i>Ce</i>           | artmen<br>rtificat          | t of H                   | lealth a<br>Death          | and M                  |                                    | Reg. No.       | 005                        | demand and     | 1528                                  |   |
|-------------------|--|-------------------|---|--|---|---------------------------------|-----------------------------|--------------------------|----------------------------|------------------------|------------------------------------|----------------|----------------------------|----------------|---------------------------------------|---|
| П                 | Physici  | an                | Decedent's Name (First, Middle,   | Last)  |   |                                 |                             | _                        |                            |                        | 2. Date of De<br>Month             | aath<br>Day    | Yea                        |                | 3. Time of Death                      |   |
|                   | /Media   | _                 | CRYSTAL   |  |   | OCK                             |                             |                          |                            |                        | 12                                 | 16             | 200                        |                | 13:25 PM                              |   |
|                   | Examin   | er                | 4a. Facility Name (If not institution,  | _  |   |                                 | 4b. City,                   | 0                        | Location of                |                        | _                                  | 4c.            | County of De               | ath            |                                       |   |
|                   |  | 4                 | JOHNS HOPKINS  5. Social Security Number  | Sex Sex                                      | 7. Age (In yrs.   |                                 | If Under                    | ) A L                    | TIN If Under               |                        | 8 Date of Bir                      | th             | 9.8                        | lirtholae      | o /State or Foreign                   | _ |
|                   | Funeral Director   |                   | 218-78-7345   | 1 □ M 2 🟋 F                                  |   | 9 Yrs.                          | Months                      |                          | Hours                      | Min.                   | 12-14                              | y, Year)       | 3. 0                       | Country        | e (State or Foreign                   |   |
|                   | in the second  |                   | Usual Residence of Decedent   |  |   |                                 |                             | -                        | 1                          |                        |                                    |                |                            | (1)            |                                       | _ |
|                   | how  |                   | 10a. State 10b. County  |  |   | ty, Town or L                   |                             |                          |                            |                        |                                    |                |                            | 10d            | . Inside City Limits                  |   |
|                   | Ba-f   | cto               | MD  |  | Ва  | ltimo                           | re                          |                          |                            |                        |                                    |                |                            |                | XXYes 2 □ No                          |   |
|                   | 를 <b>2</b> 0 원   | Director          | 10e. Street and Number  | 3  |   |                                 | 10f. Zip                    |                          |                            |                        |                                    | 10g. Citi      | zen of What                | Country        | ?                                     |   |
|                   | ath w  | ra                | 1714 Dundalk  |  |   |                                 |                             | 222                      |                            |                        |                                    | U.S            |                            |                |                                       |   |
|                   | er de  | Funeral           | <ol> <li>Marital Status</li> <li>Never Married 2 Married</li> </ol>   | Armed  |   | J.S. 13.                        | Was Dece<br>If Yes, spe     | dent of Hi<br>cify Cuba  | ispanic Ori<br>in, Mexicar | gin? (Sp<br>1, Puerto  | ecify Yes or No<br>Rican, etc.)    | D-             | 14. Race - Ar<br>Black, Wi |                |                                       |   |
| 36                | irs aft  | by F              | 3 ☐ Widowed 4XXX ivorced  | If Yes, C                                    | Sive No<br>Dates:   |                                 | 1 🗆 Yes                     | 2 🛚 No                   | Specify:                   |                        |                                    |                | Specify: N                 | ati            | ve Amer.                              |   |
| 21215-0036        | within 72 hours after death with the Maryland<br>ene.<br>than "natural", or items 23e or 28e-f ahow<br>I.a Madigal Ezaminar mual ba nodilled at  | ed<br>ed          | 15. Decedent  |  |   | 16a. Dece                       | dent's Usu                  | al Occupa                | ation                      |                        |                                    | 16b. Ki        | nd of Busines              | ss/Indus       | stry                                  | - |
| 215               | hin 7.   | pie               | (Specify only highes Elementary/Secondary (0-12)  | 1  | (1-4or 5+)  | life.                           | DO NOT u                    | ork done d<br>se retired | during mos<br>()           | t of work              | ing                                |                |                            |                |                                       |   |
|                   | or thu   | Completed         | 10th  |  |   | <u> </u>                        | Home                        | Mak                      | er                         |                        |                                    | Н              | ome                        |                |                                       | _ |
| nd                | be filed<br>tal Hygi<br>d other<br>avant, t  | Be                | 17. Father's Name (First, Middle, L   |  |   |                                 |                             |                          |                            |                        | e (First, Middle                   | , Maiden       | Sumame)                    |                |                                       |   |
| yla               | should be<br>nd Mental<br>marked c   | 은                 | Thurman L. Lo   |  |   |                                 |                             | ļ                        |                            |                        | lden                               | _              |                            |                |                                       |   |
| Maryland          | 12 short and 7 le m  | - 3               | 19a. Informant's Name/Relationsh<br>Hannah Lockle   |  |   |                                 |                             |                          |                            |                        | al Route Numb                      |                |                            | -              |                                       |   |
|                   | of Health<br>Itam 27<br>other tr   |                   | 20a. Method of Disposition  |  | 20b.  | DIZ:                            |                             |                          | ora L                      |                        | Apt. I                             |                | ndalk<br>cation - City     |                |                                       |   |
| Baltimore,        |  |                   | 1 Burial 2XX remation   |  | n State   | cemetery, cre                   | matory or o                 | other plac               |                            |                        |                                    |                |                            |                | i, State                              |   |
| 틒                 | it. Partment   |                   | 4 ☐ Donation 5 ☐ Other (Sp. 21. Signature of Funeral Service L  |  | ра  | yview                           |                             |                          |                            |                        |                                    | Dun            | dalk,                      | MD_            |                                       |   |
| Ba                | permit, Page<br>Department of<br>Important: If<br>any injury or<br>once.   |                   | 0   | 12/6   | 111   | _ 2                             | 007                         | East                     | ern                        | y we                   | sley (                             | onav           | IS Jr<br>MD 21             | . F            | 'H                                    |   |
|                   |  |                   | 23a. Part1. Enter the disease, or shock, or heart failure. List of  | complications tha                            | t caused the dea  |                                 |                             |                          |                            |                        |                                    |                | EID ZI                     | A              | pproximate<br>iterval Between         | - |
| 8760,             | battending physicien and a strending physicien and e attending physicien and identification and identificati | icai Examiner     | Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | a Due t b bue t c Due t                      | O (or as a conseive of or a conseive of or a conseive of or a conseive or a conseive of or a conseive or a conseive of or a conseive or a | quence of):                     | PRE                         | ST U                     | FA1                        | LUI                    | rE                                 |                |                            |                | nset and Death                        | _ |
| .O. Box 6         | the death certify<br>y the attending<br>ched for use as  | Physician/Medical | IF FEMALE:<br>23b. Was decedent pregnant<br>in the past 12 months?<br>1 ☐ Yes 2 ☐ No<br>9 ☑ Unknown   | 1 Live                                       | outcome of pregn<br>birth 2 Fet<br>gnant at time of<br>known  | al death 3                      | □Ectopic p<br>□ Other (sp   |                          |                            |                        |                                    |                | 23d. Date of o<br>Month    | delivery<br>Da | ay Year                               |   |
| s, D              | Se Lo  | by Р              | Part II. Other significant condition  | s contributing to                            | death but not re  | sulting in the                  | underlying o                | ause give                | en in Part I               | i.                     | 23e. Did                           | tobacco u      | se contribute              | to the         | cause of death?                       |   |
| of Vital Records, | w requir<br>been si<br>should I  | ted               | RENAL DISE  | 75E  |   |                                 |                             |                          |                            |                        | 10                                 | Yes 2          | □No 3□                     | Probab         | ly 4 🗷 Unknown                        |   |
| ဝင                | e law r<br>has be<br>je 2 sh   | Completed         |   |  |   |                                 |                             |                          |                            |                        | 24a. Was                           |                |                            |                | findings available letion of cause of |   |
| <u> </u>          | Th<br>este<br>pag  | Con               |   |  |   |                                 |                             |                          |                            |                        | perfe                              | ormed?<br>2 No | death<br>1 U Y             | ?              | □ No                                  |   |
| /ita              | iclen: Certifice   | Be                | 25. Was case referred to medical examiner?  |  |   | ,                               |                             |                          |                            | of Deat                | h Check only                       | one)           | -                          |                |                                       |   |
| )t                | Physiclen:<br>this certific<br>ral director,   | 2                 | 1 Yes 2 No  | - In the second                              |   | ER/Outpatie                     |                             |                          | 4 🗆 140                    | ursing Ho              | me 5 Res                           |                |                            | oecify)        |                                       | _ |
| Z C               |  | on                | 27. Manner of Death  1 Natural 5 Pending  | (Me  | te of Injury<br>onth, Day Year)   | 28b. Time of<br>Injury          |                             | 28c. Injun<br>Worl       |                            | No                     | 28d. Describe                      | how injur      | y occurred                 |                |                                       |   |
| Division          | ten<br>leat<br>tor:  | Certification:    | 2 Accident investig   | ot be  | ce of Injury - At h   | nome form of                    | M least factor              |                          | Yes 2 🗆                    | NO                     | 28f. Location                      | (Straat on     | d Alumbar or               | Oural O        | Touris Abombos                        |   |
| <u>&gt;</u>       | l or Attsnu<br>after deatl<br>Diractor:<br>in by the   | ertif             | 4 Homicide determine  |  | Iding, etc. (Spec   |                                 | ireet, lactor               | y, office                |                            |                        | City or To                         | wn, State      | )                          | Hurai H        | loute Number,                         |   |
|                   | To the Hospital or At within 24 hours after or To the Funeral Diract completely filled in by   | edical C          | 29a. Certifier 1 Certifyin (Check only one) 1 Medical I   | Physician: To t<br>xaminer: On the<br>and ma | he best of my kn<br>basis of examin<br>anner stated.  | owledge, dea<br>ation and/or ii | th occurred<br>nvestigation | at the tin               | ne, date ar<br>pinion, dea | nd place,<br>atn occur | and due to the<br>red at the time, | cause(s)       | and manner<br>place, and d | as state       | ed.<br>e cause(s)                     |   |
|                   | To the vithin 2 To the complet   | Me                | 29b. Signature and title of certifier   |  |   |                                 | 29                          | c. License               | e number                   |                        |                                    | 29d. Dat       | e signed (Mo               | nth, Da        | y, Year)                              | - |
|                   | 2, 0   |                   | Matthia   | MULL   | R M   | .n.                             |                             | 275                      | -0                         | 07                     |                                    | An             | 1 -                        | _ 1/           | 2005                                  |   |
|                   | 4  |                   | 30. Name and address of person  | vho completed ca                             | use of death (Ite   | m 23a) (Type                    | , Print)                    | ~                        |                            |                        |                                    | _00            | EMBE.                      | V 16           | ) -0.0                                | - |
| D                 | L.   |                   | MATTHIAS I  | <b>bLNHOP</b>                                | F 494   | 10 EA                           | - En                        | VA                       | VEN                        | EL                     | ar im                              | ONE            | mn                         | 2/0            | 24                                    |   |
|                   | Sta<br>Regist  |                   | 31. Date filed (Month, Day, Year)   | -  | Registrar's Sign  | ature                           | Local                       | 60                       |                            |                        | 7,                                 |                |                            |                |                                       |   |

|                   |   |                  | 1 - For<br>Registrar  | State of Mar  |                                    | artment of H                                  |                               | and Mental Hy                                    | giefie   | 5 41529  |
|-------------------|---|------------------|---|---|------------------------------------|---|-------------------------------|--|--|--|
|                   | ę.  | ¢ .              | Decedent's Name (First, Middle, Last  | it)   |                                    |   |                               | 2. Date of De                                    | ath  | 3. Time of Death   |
|                   | Physici   |                  | Edward M  | iller   |                                    |   |                               | Month<br>DECEM                                   |  | 2005 18:19 M   |
|                   | /Medio  |                  | 4a. Facility Name (If not institution, give   |   |                                    | 4b. City, Town, or                            |                               | f Death  | 4c. County o                                     |  |
|                   |   | Ay .             | JOHNS HOPKING   | S BAYVIEW   | 1 MEDICALS                         | GUTER F                                       | SALT                          | IMORE  |  |  |
| 1                 | Funeral   |                  | 5. Social Security Number 6. S 214-40-2855  | ex 7. Age (<br>XM 2 □ F   | In yrs. last birthday)             | If Under 1 Year<br>Months Days                | If Under 2<br>Hours           | Min. 8. Date of Bir<br>(Month, Da                | th<br>ly, Year)                                  | Birthplace (State or Foreign Country)                                  |
|                   | Director  |                  | Usual Residence of Decedent   | <b>4</b> 23.  | 64 Yrs.                            |   |                               | August 17  | 7,1941   | Maryland   |
|                   | and wo  |                  | 10a. State 10b. County  | 1   | Oc. City, Town or Lo               | cation  |                               |  |  | 10d. Inside City Limits  |
|                   | the Marylan<br>28a-f show<br>notified at  | ţ                | MD. Baltimo   | re  | Dunda                              | lk  |                               |  |  | 1 ☐ Yes 2 X No   |
|                   | or 28a  | irec             | 10e. Street and Number  |   |                                    | 10f. Zip Code                                 |                               |  | 10g. Citizen of Wi                               | hat Country?   |
|                   | 23a c   | a                | 6948 Broening Roa   | đ   |                                    | 21222   |                               |  | USA  |  |
|                   | r dea   | Funeral Director | 11. Marital Status  | 12. Was Decedent Eve<br>Armed Forces?                                       | er in U.S. 13. V                   | Was Decedent of Hi<br>f Yes, specify Cuba     | ispanic Orig                  | gin? (Specify Yes or No<br>, Puerto Rican, etc.) | - 14. Race<br>Black                              | - American Indian,<br>, White, etc.                                    |
| 36                | s afte  | by Fi            | 1 X Never Married 2  Married<br>3  Widowed 4  Divorced  | 1 X Yes 2 ☐ No<br>If Yes, Give  |                                    | 1 ☐ Yes 21 No                                 | Specify:                      |  |  | White  |
| 21215-0036        | filed within 72 hours after death with the Maryland<br>Hygiene.<br>ther than "natural", or tleme 23a or 28a-f ahow<br>thit, tha Madical Evarriner must be notified at | edt              | 15. Decedent's Ed   | Year or Dates:  | 16a Decer                          | ient's Usual Occupa                           | ation                         |  | 16b. Kind of Bus                                 |  |
| 15                | n "na   | plet             | (Specify only highest gra   | de completed)   | (Give                              | kind of work done of<br>OO NOT use retired    | during most                   | of working                                       |  | ent of Defense   |
| 212               | d with<br>giene<br>or the   | Completed        | 12 years  | College (1-4or 5+)  |                                    | estigator                                     | 2                             |  |  | vernment   |
|                   | 2 should be filed withir<br>and Mental Hygiene.<br>Is marked other than<br>eumatic event, tha Me  | Bec              | 17. Father's Name (First, Middle, Last)   |   |                                    |   | 18. Mother                    | r's Name (First, Middle,                         | Maiden Sumame                                    | )  |
| Maryland          | should be fand Mental I   | 2                | George Miller   |   |                                    |   |                               | y Connelly                                       |  |  |
| lar               | 2 sh<br>and<br>and<br>ts m  |                  | 19a. Informant's Name/Relationship (  | •                                     |                                    |   |                               | r or Rural Route Numbe                           |  |  |
|                   | 1 and<br>Health<br>em 27  |                  | John Miller  20a. Method of Disposition   | Brother   | 6948<br>20b. Place of Dispo        |   | J Roac                        | d, Baltimor                                      |  | ZZZ<br>lity or Town, State   |
| Baltimore,        | of the  |                  | 1X Burial 2 Cremation 3   | Removal from State  | cemetery, cren                     | natory or other plac                          | e) D                          | ecember  |  |  |
| Ħ                 | permit. Pag<br>Department<br>Importent: I<br>any Injury o   |                  | 4 □ Donation 5 □ Other (Specify 21 Signature of Egneral Service Lice)                                       |   | Sacred Hear                        |   |                               |  | Dundalk,   |  |
| Ba                | permit. Departr Importe any Inji  |                  | Datus ml  | X   | 7                                  | onnelly I                                     | unera                         | il Home Of I                                     | Dundalk,<br>Dundalk 1                            | P.A.<br>MD. 21222  |
| 20.0              | phone   |                  | 23a. Part1. Enter the disease, or com-<br>shock or heart failure. List only                                 | plications that caused the  |                                    |   |                               |  |  | Approximate<br>Interval Between  |
|                   | Physician   | . 0              | Immediate Cause (Final disease or condition   | -   | BRAL I                             | _   |                               |  |  | Onset and Death  |
|                   | /Medical<br>Examiner  |                  | resulting in death)   | W1  | consequence of):                   |   |                               |  |  | a Dhy 3  |
| П                 | Examiner  |                  | Sequentially list conditions,   | b   |                                    |   |                               |  |  |  |
| V                 | ed sit  | olner            | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | Due to (or as a c   | consequence of):                   |   |                               |  |  |  |
| •                 | xecul<br>r and<br>al-trar   | Examine          | that initiated events resulting in death) Last  | c. Due to (or as a c  | consequence of):                   |   |                               |  |  |  |
| 8760,             | cate be executed<br>physicien and<br>the burial-transit   | dical            | (   | d   |                                    |   |                               |  |  |  |
| 9                 | ificati<br>g phy<br>as the  | 100              |   | u   |                                    |   |                               |  |  |  |
| Box               | eath certific<br>attending p  | N/UE             | IF FEMALE:<br>23b. Was decedent pregnant  | 23c. If yes, outcome of 1□Live birth 2                                      | pregnancy                          | Ectopic pregnancy                             |                               |  | 23d. Date  | of delivery  |
| _                 | The law requires that the death certifi<br>sie has been signed by the attending i<br>age 2 should be detached for use as  | Physician/M      | in the past 12 months? 1 Yes 2 No   | 4☐Pregnant at tin   |                                    | Other (specify)                               |                               |  | Mont   | h Day Year   |
| P.0               | that the de<br>ted by the a<br>detached f   | Phy              | 9 Unknown   |   |                                    |   |                               |  |  |  |
| JS,               | uires tha<br>signed<br>id be det  | <u>8</u>         | Part II. Other significant conditions of  | ^   |                                    | 21 LLATI                                      |                               | 230. Did to                                      |  | oute to the cause of death?  |
| Ö                 | w requ  | Completed        |   | 73161   | nr 115                             | ~ \   | 010                           |  |  |  |
| Rec               | has<br>has  | ш                | DIABETES  |   |                                    |   |                               | 24a. Was<br>autop                                | osy pri  | ere autopsy findings available<br>or to completion of cause of<br>ath? |
| a                 |   | မ Co             | 25 Was sage referred to market  |   |                                    |   |                               | 1 ☐ Yes  | 208No 10   | Yes 2 No   |
| of Vital Records, | Physician:<br>rthis certificaral director,  | <b>6</b> 0       | 25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No   | Hospital:   | 2 ☐ ER/Outpatien                   | t 3 DOA Othe                                  | 20                            | of Death (Check only of<br>sing Home 5 Resid     |  | (0(-)  |
| o                 | g Phy<br>ler this<br>neral c  | ت<br>۲           | 27. Manner of Death   | 28a. Date of Injury<br>(Month, Day Y  | 28b. Time of                       |   |                               |  | now injury occurred                              |  |
| jo                | ath.<br>eath.<br>or: After  | atlo             | 1 Natural 5 ☐ Pending<br>2 ☐ Accident investigation   |   | 'ear) Injury                       |   | Yes 2 □ N                     | lo   |  |  |
| Division          | r Atti  | Certification:   | 3 ☐ Suicide 6 ☐ Could not be<br>4 ☐ Homicide determined   | 28e. Place of Injury<br>building, etc. (                                    | - At home, farm, stre<br>(Specify) | eet, factory, office                          |                               | 28f. Location (S<br>City or Tow                  | Street and Number                                | or Rural Route Number,   |
| Q                 | urs af<br>urel D<br>led ir  |                  |   |   |                                    |   |                               |  |  |  |
|                   | To the Hospital or Attending within 24 hours after death.  To the Funerel Director: Attencompletely filled in by the funer  | Medical          | 29a. Certifier (Check only one)  1 Certifying Ph 2 Medical Exam   | y sician: To the best of r<br>niner: On the basis of ex<br>and manner state | xamination and/or inv              | occurred at the time<br>restigation, in my op | ne, date and<br>pinion, death | place, and due to the on occurred at the time,   | cau <i>s</i> e(s) and mani<br>date and place, an | ner as stated. Indicate to the cause(s)                                |
|                   | omple   | Me               | 29b. Signature and title of certifier   |   |                                    | 29c. License                                  | number                        |  | 29d. Date signed (                               | (Month, Day, Year)   |
|                   | >=0   |                  |   | IXE   | SIDENT                             | RE  | ES- (                         | 000  | DECEM BE   | ER 22,2005   |
|                   | 6   |                  | 30. Name and address of person who  | completed cause of dea  | th (Item 23a) (Type,               | Print)  |                               |  |  | · · · · · · · · · · · · · · · · · · ·                                  |
|                   |   |                  | DR. DINAKAR   | JOHNS   | HOPKINS                            | BMC . 49                                      | 40, E.                        | ASTERN A   | IENUE  | BALTIMORE  |
|                   | Sta   | -                | 31. Date filed (Month, Day, Year)   | 32. Egistrar's  | s Signature                        | 12.16   |                               |  |  | BALTIMORE<br>MD-21224  |
| el (40)           | Registr   | ar               | DEC 2 3 2   | JUD CUL   | JA P                               |   |                               |  |  | ,  |

|             |   |                  | 1 - For State Registrar  |  | urtment of Health and Matricate of Death   | Mental Hygier                                    | 2000 41000   |
|-------------|---|------------------|--|--|--|--|--|
| 7           | Physici   |                  | 1. Decedent's Name (First, Middle, Last)  JoAnne P. Miller   |  |  | 2. Date of Death<br>Month<br>December            | Day Year 21, 2005 1:55 p M   |
|             | /Medie<br>Examir  |                  | 4a. Facility Name (If not institution, give street an<br>Gilchrist Hospice Ce                      |  | 4b. City, Town, or Location of Death Towson  |  | 4c. County of Death Baltimore  |
|             | Funeral<br>Director   |                  | 5. Social Security Number 6. Sex 129-32-7612   | 7. Age (In yrs. last birthday)   | If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.   | 8. Date of Birth<br>(Month, Day, Ye<br>May 20, 1 | 9. Birthplace (State or Foreign<br>Scountry)<br>New York                                   |
|             | Maryland -f ehow  | tor              | Usual Residence of Decedent  10a. State  10b. County  Md. Harford                                  | 10c. City, Town or Lo  | cation   |  | 10d. Inside City Limits 1 ☐ Yes 2 ☐ No   |
|             | h with the  | al Director      | 10e. Street and Number<br>2020 Mardic Drive  | 1016.  | 10f. Zip Code 21050  |  | Citizen ol What Country? U.S.A.  |
| 980         | ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "naturel", or iteme 23a or 28a-1 show or other traumetic event, the Medical Examiner must be notified at | by Funeral       | 1 Never Married 2 Married 1 If Ye  | ed Forces?<br>Yes 2 📉 No   | Nas Decedent ol Hispanic Origin? (SylyYes, specify Cuban, Mexican, Puerto     □ Yes 2 Xno Specify:           | pecify Yes or No-<br>p Rican, etc.)              | 14. Race - American Indian, Black, White, etc.  Specify: White                             |
| 21215-0036  |   | Completed        | 15. Decedent's Education (Specify only highest grade comple Elementary/Secondary (0-12) Colle      | eted) (Give<br>life. I   | lent's Usual Occupation<br>kind of work done during most of work<br>DO NOT use retired)<br>Chool teacher aid | king   | . Kind of Business/Industry  |
| Maryland 2  | uld be filed<br>Mental Hygi<br>irked other<br>itic event, I   | To Be C          | 17. Father's Name (First, Middle, Last) William W. Conway  |  |  | ne (First, Middle, Maid<br>Shannon               | den Sumame)  |
| Mary        | d 2 sho th and the  |                  | 19a. Informant's Name/Relationship (Type, Prin<br>Eugene J. Miller, Jr                             |  | g Address (Street and Number or Ru. ) Mardic Drive, Fo   |  |  |
| Baltimore,  | permit. Pages 1 and 2 should be filed within Deperment of Health and Mental Hygiene. Important: If item 27 is marked other than 's may highty or other traumatic event, the Maone.  |                  | 20a. Method of Disposition  1 △ Burial 2 □ Cremation 3 □ Removal  4 □ Donation 5 □ Other (Specify) | 20b. Place of Dispo<br>cemetery, cren  | sition (Name of natory or other place)   | Date 20c.  | Location - City or Town, State  1timore, Md.   |
| Balt        | permit. Depertrimports any inju   |                  | 21. Signature of Funeral Service to Cense.   |  | Name and Address of Facility<br>Chimunek Funeral I<br>O W. MacPhail Ros                                      |  |  |
| X           | Physician<br>/Medical<br>Examiner   |                  | Sequentially list conditions b.  | that caused the death. Do not entry on each line.  Complete to (or as a consequence of): | er the mode of dying, such as cardiac  | or respiratory arrest,                           | Approximate Interval Between Onset and Death   |
| 8760, <     | The law requires that the death certificate be executed the has been signed by the ettending physician and bage 2 should be detached for use as the burlat-transit  | dical Examiner   | cause. Enter Underlying Cause (Disease or injury that initiated events  c.                         | ue to (or as a consequence of):  |  |  |  |
| O. Box 6    | that the death certific<br>ed by the ettending p<br>detached for use as   | Physician/Med    | in the past 12 months?   |  | Ectopic pregnancy<br>  Other (specify)   | 111  | 23d. Date of delivery<br>Month Day Year  |
| ords, P.    | w requires that<br>been signed t<br>should be det   | þ                | Part II. Other significant conditions contributing   | g to death but not resulting in the un   | nderlying cause given in Part I.   | 23e. Did tobaco                                  | co use contribute to the cause of death? 2 No 3 Probably 4 Winknown                        |
| al Records, |   | Completed        |  |  |  | 24a. Was an autopsy performed 1 Yes 2 1          | 24b. Were autopsy lindings available prior to completion of cause of death?  No 1 Yes 2 No |
| of Vital    | Physician: The this certificate ral director, pag   | To Be            | 25. Was case relerred to medical examiner?  1 ☐ Yes 2 ☒ No Hospital:                               | 1 ☐ Inpatient 2 ☐ ER/Outpatien   | 0.0  | th (Check only one)                              | 6 Depther (Specify) VOSPLO   |
| Division of | fing<br>After<br>fune   | Certification: T | 2 ☐ Accident investigation   | Date of Injury<br>(Month, Day Year) 28b. Time of<br>Injury                               | 28c. Injury at Work? M 1 Yes 2 No  | 28d. Describe how in                             |  |
| Divi        | To the Hospital or Attending within 24 hours after death.  To the Funeral Director: Attencompletely filled in by the fune   |                  | 4   Homicide   | Place of Injury - At home, farm, strobuilding, etc. (Specify)                            |  | City or Town, St                                 |  |
|             | the Hosp<br>nin 24 ho<br>the Fune   | ledicai          | (Check only /2   Medical Exeminer: On  | the basis of examination and/or inv  | occurred at the time, date and place,<br>restigation, in my opinion, death occur                             | red at the time, date a                          | and place, and due to the cause(s)   |
| •           | with Con  | Σ                | 29b. Signature and title of certifier  | Par  | 29c. License number  D 58303   | 29d.   | Date signed (Month, Day, Year)  CCMCC 21 2005  |
|             | 12  |                  | 30. Name and address of person who completed   | cause of death (Item 23a) (Type,   | Print) St POWSON!  | no 2120  | 24   |
|             | Sta<br>Regist   |                  | 31. Date lited (Month, Day, Year) DEC 2 3 2005   | 32. Registrar's Signature  | 29c. License number D 58303 Print) St Powson   |  |  |

Duenber 21, 2005 155 pm

|                   |  |                     | Please I  | ype or Print in Blac   |  |   | -  | _   |                                 |
|-------------------|--|---------------------|---|--|--|---|--|---|---------------------------------|
|                   |  |                     | For State   | State of Maryland /  |  |   | Mental Hygien                                      | e005 41   | 531                             |
| _                 |  |                     | Registrar   |  | Certificate of   | f Death                                       | Reg. N   |   |                                 |
|                   | Physici<br>/Medic  |                     | 1. Decedent's Name (First, Middle, Last)  Dolores   | Murra  | <b>Y</b>   |   | December   | 20,2005 9   | ime of Death A                  |
|                   | Examin   | er                  | 4a. Facility Name (If not institution, give s   | 100  | D  | or Location of Death                          | 10-0   | c. County of Death  |                                 |
|                   | Funeral  |                     | 5. Social Security Number 6. Sex  |  | een If Under 1 Yea   |   | 8. Date of Birth                                   | 9. Birtholace (   | State or Foreign                |
|                   | Director   |                     | Usual Residence of Decedent   | M 2×F 82   | Yrs. Months Days   | s Hours Min.                                  | 8. Date of Birth<br>Month, Day, Yea                | Spuntry)  | land                            |
|                   | s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other then "natural", or items 23a or 28e-f show other traumatic event, it is Medical Executive frust by rolling a | ž                   | 10a. State 10b. County  | 10c. City, Tov   | vn or Location   |   |  |   | side City Limits<br>XYes 2 □ No |
|                   | 286-1  | by Funeral Director | 10e. Street and Number  | Bo   | 10f. Zip Code  |   | 10n C  | itizen of What Country?   |                                 |
|                   | h with   | ID Is               | 318 N. Call   | roun St  | 213  | カクろ   | 109.0  | 11 <a< td=""><td></td></a<>   |                                 |
|                   | ems ?  | iner                |   | Was Decedent Ever in U.S.<br>Armed Forces?   | 13. Was Decedent of<br>If Yes, specify Cu                                  | Hispanic Origin? (Sp                          | pecify Yes or No-                                  | 14. Race - American Ind<br>Black, White, etc.                                     | ian,                            |
| 36                | s afte   | y Fu                | 1 Never Married 2 Married   | 1 ☐ Yes 2 ☑ No<br>If Yes, Give<br>Year or Dates:   | 1 ☐ Yes 2 🕱 N  |   | , , , , ,  | Specify: D  | i                               |
| 8                 | hour   | ed b                | 3 XWidowed 4 ☐ Divorced  15. Decedent's Educ  |  | Decedent's Heuri Occi  | unation                                       | 160  | Kind of Business/Industry   |                                 |
| 21215-0036        | nin 72<br>an na  | Completed           | (Specify only highest grade<br>Elementary/Şecondary (0-12)  | Completed)  College (1-4or 5+)   | Decedent's Usual Occi<br>(Give kind of work don-<br>life. DO NOT use retir | e during most of work<br>red)                 | king   | Kind of Business/Industry   |                                 |
| 21                | filed with<br>Hygiene<br>other the   | Com                 | 12  | Oquege (1-451 34)  | Home 1   | Visitor                                       | - B  | alto. Public  | Schools                         |
| Ind               | be file<br>d oth   | Be                  | 17. Father's Name (First, Middle, Last)   | 1  |  | 18. Mother's Nam                              | e (First, Middle, Maide                            | n Sumame)   |                                 |
| Maryland          | 2 should be filed withir and Mental Hygiene. Is marked other then aumatic event, Italia  | ī                   | Amos Ba   | Ker  | h Al-III Adding (O)  | Emr   | na Bo  | one   |                                 |
| Ma                | id 2 slith an Ith an traur   |                     | 19a. Informant's Name/Relationship (Ty)   | daughter)  | D. Malling Address (Street)  |   | t Ave. B   | or Town, State, Zip Code)   | 21211                           |
| ē,                | s 1 and<br>f Health<br>item 27<br>other tr   |                     | 20a. Method of Disposition  | comot  | of Disposition (Name of<br>ery, crematory or other pi                      | (200)   |  | Location - City or Town, St   | ate                             |
| E                 | Pages<br>nent of I<br>int: If it   |                     | 1  Burial 2  Cremation 3  R  1  Other (Specify)   | emoval from State  | Son For  | 12/2  | 9/2005 1   | lings Mill  | < Md.                           |
| Baltimore,        | permit. Pages 1 and Department of Health Important: If item 27 any injury or other tr once.  |                     | 21. Signature of Funeral Service cicense  |  | 22. Name and Add   | ress of Facility                              | Funeral  | Home P.A.   | 2,1100                          |
| ī                 | 40340  |                     | 23a. Part Finter the disease, or compli   | cations that cansed the death. Do  | not enter the mode of the  | North A                                       | ve. Balto  | Md. 21216   | oximate                         |
|                   | Dhysisian  |                     | 23a. Part : enter the disease, or complished or heart failure. List only on Immediate Cause (Final          | e cause on each line.  | CEROTI   | cant  |  | Interv  | al Between<br>t and Death       |
|                   | Physician /Medical   |                     | disease or condition resulting in death)  | Due to (or as a consequence  |  |   | DIZE   | 32W   |                                 |
| н                 | Examiner   |                     | Sequentially list conditions  |  |  |   |  |   |                                 |
| -                 | /p =   | Iner                | Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury | Due to (or as a consequence  | of):   |   |  |   |                                 |
| V                 | xecute<br>and<br>Il-tran   | Examiner            | that initiated events resulting in death) Last  | Due to (or as a consequence  | of):   |   |  |   |                                 |
| 760,              | eath certificate be executed attending physician and for use as the burial-transit   | calE                |   |  |  |   |  |   |                                 |
| 68                | tificate<br>ig phy<br>as the   | ledic               |   |  |  |   |  |   |                                 |
| Вох               | th cer<br>tendir<br>r use  | an/N                | 230. Was decedent pregnant  | 3c. If yes, outcome of pregnancy<br>1☐Live birth 2☐Fetel deat                                | n 3 ⊟Ectopic pregnan   | cv  |  | 23d. Date of delivery   |                                 |
| O. E              | that the death cer<br>ed by the attendir<br>detached for use   | Physician/Medi      | in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown   | 4☐Pregnant at time of death 9☐ Unknown   | 5 Other (specify)  |   |  | Month Day   | Year                            |
| P.O.              | that the od by detac   |                     | Part II. Other significant conditions con   | tributing to death but not resulting   | in the underlying cause o  | iven in Part I.                               | 23e. Did tobacco                                   | use contribute to the caus  | se of death?                    |
| of Vital Records, | The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit   | ed by               |   |  |  |   | 1 ☐ Yes 2  | 2 No 3 Probably   | 4 Unknown                       |
| 000               | aw requir<br>ts been si<br>2 should t  | plet                |   |  |  |   | 24a. Was an  | 24b. Were autopsy find  | dings available                 |
| Ä                 | The ate his  | Completed           |   |  |  |   | autopsy performed?                                 | prior to completion death?  |                                 |
| /ita              | Physicien:<br>this certificatal director, I  | Be                  | 25. Was case referred to medical examiner?  | agaital.   |  |   | th (Check only one)                                |   | 7                               |
| of o              | Physic<br>this c   | - T                 | 1 Yes 2 No  | ospital: 1 Inpatient 2 ER/O  | utpatient 3 DOA  |   | ome 5 Residence                                    |   |                                 |
|                   | ding<br>th.<br>After<br>funer  | tlon                | Natural 5 Pending 2 Accident investigation  |  | Injury W   | uryat<br>ork?<br>□Yes 2□No                    | 28d. Describe how inju                             | ary occurred  |                                 |
| Division          | Atter<br>er dea<br>ector<br>by the   | Certification;      | 3 Suicide 6 Could not be  | 28e. Place of Injury - At home, f<br>building, etc. (Specify)                                | arm, street, factory, office   | •   | 28f. Location (Street a<br>City or Town, State     | and Number or Rural Route   | Number,                         |
| Ö                 | oitel or<br>urs aft<br>rel Dir<br>illed in   |                     |   |  |  |   |  |   |                                 |
|                   | To the Hospitel or Attending Physicien: The law within 24 hours after death.  To the Funerel Director: After this certilicate has completely filled in by the funeral director, page 2   | Medical             | 29a. Certifier (Check only one) 2 Medicel Examin  | ician: To the best of my knowledg<br>er: On the basis of examination a<br>and manner stated. | e, death occurred at the nd/or investigation, in my                        | time, date and place,<br>opinion, death occur | and due to the cause(s<br>red at the time, date an | <ul> <li>s) and manner as stated.</li> <li>nd place, and due to the ca</li> </ul> | iuse(s)                         |
|                   | To th<br>withir<br>To th<br>comp   | Me                  | 29b. Signature and title of certifier   | 0 00   | Dr. 1 290 Licer  | nse number                                    | 29d. Da  | ate signed (Month, Day, Y   | ear)                            |
| •                 |  |                     | Horal   | -15.00   | -1   | 2168  | 20   | 12/21/  | 05                              |
|                   | 6  |                     | 30. Name and address of person who co   |  | (Type Print)   | 717 PA  | RX HS  | 214131  | MENCE                           |
|                   | Sta  |                     | 31. Date filed (Month, Day, Year)   | 32. Registrar's Signature  |  |   |  |   |                                 |
|                   | Registr  | rar                 | DEC 2 3 20  | 05 6   | A  |   |  |   |                                 |

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For Amend Items# 15 tate 20 Maryland Caratter of Death Registrar 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month Year **Physician** December 21,2005 161 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Gyn1 If Under 1 Year saltimore SOI Va If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Social Security Number 6. Sex Min. **Funeral** Days Hours 224-14-852 Usual Residence of Decedent 1 □ M 2 🛛 F Months 9 159 Inia Director 10d. Inside City Limits death with the Maryland 10c. City. Town or Location 10a. State 10b. County 28a-f show ir than "natural", or Itams 23s or 28s-f shov the Medical Expriser must be notified at 1XYes 2 □ No Director Maryland timore n 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Q or Funeral 12. Was Decedent Ever in U.S. Amed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status filed within 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. ant: If item 27 is marked other than ury or other traumatic evant, tra Ms College (1-4or 5+) er 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be PETE DAVIS tand a unt 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21207 19a. Informant's Name/Relationship (Type, Print) (niece) Jok, Md 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Windsor Date 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 12/28/2005 Department o important: If any injury or once. KING MEM. PARK \* 4 ☐ Donation 5 ☐ Other (Specify) unk 22. Name and Address of Facility
Joseph L. Russ Funeral Home, P.A.
2222 W. North Ave. Balto. Md. 21216 of Funeral Service Kicensee 21. Signature Part1. Efter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock of heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Candiovascular Diseas Zoylas Physician a. Arterioscleratio disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to inmediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine anding physicien and use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23d. Date of deliven 23b. Was decedent pregnant 3 Ectopic pregnancy atten Month Day Year jo in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) certificate has been signed by the a irector, page 2 should be detached to 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 3 ☐ Probably 4 ☐Unknown 1 ☐ Yes 2 😿 No Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death? 2 🗆 No 1 ☐ Yes 2 **X** No 1 Yes or Attanding Physician: 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? Other: 4 Nursing Home Hospital: 5 Residence 6 □Other (Specify) 1 Inpatient 2 EP/Outpatient 3 DOA Certification; To 1 Yes 2 □ No 28a. Date of Injury (Month, Day Year) filled in by the funeral 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No s after death. 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide To the Hospital within 24 hours a
To the Funeral I
completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certified

State Registrar

DHMH 17 Rev 1/2001

DEC 2 3 2005

31. Date filed (Month, Day, Year)

Mili

6 Trimble Hill

2Dut

gistrar's Signature

30. Name and address of person who completed cause of death (It in 23a) (Type, Print)

2110

December 22, 2005

Maryland

Lythery ! le

|  |                  | For Stata  | State of Marylan  |                       | artment of I                           |   |   | 2111  | 5 L                         | 1533                  |  |  |
|--|------------------|--|---|-----------------------|--|---|---|---|-----------------------------|-----------------------|--|--|
|  |                  | Ragistrar  1. Decedent's Name (First, Middle, Last)  |   | Cer                   | TITICATE OF                            | Death                                     | 2. Date of Dea  | Reg. No.                                    | -                           | 3. Time of Death      |  |  |
| Physicia   |                  | HENRY E. MEESING   |   |                       |  |   |   | Day<br>19                                   | Year<br>05                  | Q 40 AM               |  |  |
| /Medica  |                  | 4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death   |   |                       |  |   |   | 4c. County                                  |                             |                       |  |  |
| LAUTING  | "                | St. Joseph Medic   | al Center   |                       | Towson                                 |   |   | Bal   | timore                      | 2                     |  |  |
| Funeral  |                  | 5. Social Security Number 6. Sex   | M 2□F 7. Age (In yrs.   |                       | If Under 1 Year<br>Months Days         |   | 8. Date of Birth  | Year)                                       | Counti                      | ace (State or Foreign |  |  |
| Director   |                  | 218-07-3122 X  | M 20 F   84   | Yrs.                  |  |   | Month, Day<br>Dec. 26   | 5, 1920                                     | Mary]                       | Land                  |  |  |
| land ow  | 1                | 10a. State 10b. County   | 10c. Cit  | y, Town or Lo         | cation                                 |   |   |   | 10                          | d. Inside City Limits |  |  |
| Mary   | ţ                | Maryland Baltimo   | re  | Phoeni                | ×                                      |   |   |   |                             | 1 □ Yes Z□No          |  |  |
| illed within 72 hours after death with the Maryland Hygiene.  Hygiene.  ther then "nature!", or items 23s or 28s-f show ont, the Medical Examination must be notified at   | Funeral Director | 10e. Street and Number   |   |                       | 10f. Zip Code                          |   |   | 10g. Citizen of                             | What Count                  | ry?                   |  |  |
| ath wi   | <u>e</u>         | 21 Trojan Horse  | Drive   |                       | 2113                                   | 31  |   | USA   |                             |                       |  |  |
| er des   | nue              |  | <ol><li>Was Decedent Ever in U<br/>Armed Forces?</li></ol>                  | .S. 13. V             | Was Decedent of<br>f Yes, specify Cub  | Hispanic Origin? (S<br>ban, Mexican, Puer | pecify Yes or No-<br>to Rican, etc.)  | 14. Rad<br>Blad                             | e - Amenca<br>ck, White, e  |                       |  |  |
| rs after   | by F             | 1 Never Married 2 Married 3 Widowed 4 Divorced   | 1 X Yes 2 □ No<br>If Yes, Give<br>Year or Dates: WWI]                       | .   1                 | 1□Yes 2X No                            | Specify:                                  |   | Specif                                      | Specify: White              |                       |  |  |
| 2 hou  | ted              | 15. Decedent's Educ  | ation   | 16a. Deced            | ient's Usual Occu                      | pation                                    |   | 16b. Kind of B                              |                             |                       |  |  |
| P. P   | ple              | (Specify only highest grade<br>Elementary/Secondary (0-12)   | Completed) College (1-4or 5+)   | life. L               | kind of work done<br>DO NOT use retire | during most of wo<br>ed)                  | rking   |   |                             |                       |  |  |
| ed will  | Completed        |  | 4   | Bank                  | er Vice                                | Presiden                                  |   | Md. Na                                      |                             | Bank                  |  |  |
| d be fill the control of the control | a a              | 17. Father's Name (First, Middle, Last)  | 6   |                       |  |   | ne (First, Middle,  |   | ne)                         |                       |  |  |
| should be<br>nd Mental<br>marked o   | ှ                | Henry C. Mo  19a. Informant's Name/Relationship (Type  | esinger, Sr.  | 10h Mailie            | a Addensa /Stree                       | t and Number or Ri                        | ricka Wi  |   | Ctata Zia (                 | 0-4-1                 |  |  |
| Taga C   | - 1              | Suzanne Duda / Fri   | •   |                       |  | se Drive                                  |   |   |                             | J008)                 |  |  |
| Dattimore, w permit. Pages 1 and Department of Health Important: if item 27 eny injury or other tr   |                  | 20a. Method of Disposition   |   |                       |  |   | Date  | 20c. Location                               |                             | vn, State             |  |  |
| Pages nent of int: If it   |                  | 20a. Method of Disposition  1  |   |                       |  |   |   | Parkville, Maryland                         |                             |                       |  |  |
| mit. Pages partment of portent: If it y injury or const.   |                  |  |   |                       |  |   |   |   |                             | York Road             |  |  |
| Dermi<br>Depa<br>Impool  |                  | 1/1/1/1  | Earl L. Canap   | p,CFSP                | Ruck To                                | wson Fund                                 | eral Home   | e, Inc.                                     |                             |                       |  |  |
|  |                  | 23a + a 2 E yer the isease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, in failure. List only one cause on each line.  Approximate Interval Between |   |                       |  |   |   |   |                             |                       |  |  |
| Physician  |                  | Immediate Clase (Final disease or X ndition resulting in death)  a   |   |                       |  |   |   |   |                             | Onset and Death       |  |  |
| /Medical<br>Examiner   |                  |  |   |                       |  |   |   |   |                             | 8                     |  |  |
|  | <u>ا</u>         | Sequentially list conditions,  | o. Procumon / A  ue to (or as a consequence of):                            |                       |  |   |   |   |                             |                       |  |  |
| the Tise   | Examiner         | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury  |   |                       |  |   |   |   |                             |                       |  |  |
| exection and ital-tra  | Exa              | that initiated events cresulting in death) Last  | Due to (or as a consec  | uence of):            |  |   |   |   |                             |                       |  |  |
| eath certificate be executed attending physician and for use es the burial-transit   | Cai              | d. Deristan  |   |                       |  |   |   |   |                             |                       |  |  |
| ntifica<br>ng ph   | Med              | IF FEMALE:   |   |                       |  |   |   |   |                             |                       |  |  |
| ath cer<br>tendin  | Physician/Med    | 23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy  |   |                       |  |   | 23d. Date of Month  |   |                             | y<br>Day Year         |  |  |
| law requires that the death law requires that the death se been signed by the atter 2 should be detached for u   | /sici            | 1 Yes 2 No   | 4 Pregnant at time of c<br>9 Unknown  | leath 5□              | Other (specify) _                      |   |   | IVIC  | Antii L                     | 7 1 6ai               |  |  |
| thet the ad by detac   |                  | Part II. Other significant conditions con  | tributing to death but not res  | ulting in the u       | nderlying cause o                      | iven in Part I.                           | 23e, Did to   | pacco use contribute to the cause of death? |                             |                       |  |  |
| uires the  | d by             |  |   |                       |  |   |   |   | s 2 No 3 Probably 4 Unknown |                       |  |  |
| w require  | Completed        |  | 24a. Was a  |                       |  |   |   |   |                             |                       |  |  |
| OI VICAL DEC<br>Physician: The lav<br>this certificete hes<br>al director, page 2  | E                |  |   |                       |  |   | autop<br>perfor   | sy<br>med?                                  | prior to com<br>death?      | pletion of cause of   |  |  |
| rifficer property  | 0                | 25. Was case referred to medical   |   |                       |  | 26. Place of De                           | 1 ☐ Yes<br>ath (Check only or   |   | 1 ☐ Yes 2                   | 2□ No                 |  |  |
| nysici<br>nysici<br>nis cer<br>direc   | 20 B             | examiner?<br>1 ☐ Yes 2 ☑ No  | ospital:  | ER/Outpatien          | t 3 DOA                                | thor                                      | Home 5 ☐ Residence 6 ☐ Other (Specify)  |   |                             |                       |  |  |
| 70 00  |                  | 27. Manner of Death 1 ☑ Natural 5 ☐ Pending  | 28a. Date of Injury (Month, Day Year) 28b. Time of Injury at Work?          |                       |  | ury at                                    | 28d. Describe how injury occurred   |   |                             | -                     |  |  |
| Attending Physician: r death. sctor: After this certific by the funeral director.  | catio            | 2 Accident investigation 3 Suicide 6 Could not be  |   |                       | M 1                                    | ]Yes 2 □No                                |   |   |                             |                       |  |  |
| or Atten<br>ther deal<br>or by the   | ertification:    | 4 Homicide determined  | 28e. Place of Injury - At h<br>building, etc. (Special                      | ome, farm, str<br>fy) | eet, factory, office                   | •   | 28f. Location (Street and Number or Rural Route Number,<br>City or Town, State) |   |                             |                       |  |  |
| spitel<br>ours sours stilled   | O                | 29a. Certifier 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |   |                       |  |   |   |   |                             | ted                   |  |  |
| Hos<br>24 h  | edical           | (Check only 2 Medical Examinations)  | nar: On the basis of examina<br>and mariner stated.                         | ation and/or in       | vestigation, in my                     | opinion, death occi                       | arred at the time, o  | date and place,                             | and due to t                | the cause(s)          |  |  |
| To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the fun   | Me               | 29b. Signature and title of certifier  | 1   |                       |  | se number                                 |   | 29d. Date signe                             | d (Month, D                 | Pay, Year)            |  |  |
|  |                  | 6- Shirty  | pleted cause of death (Item 23a) (Type, Print)  SESSEN: MO - St., Tosiff Et |                       |  |   |   | I2/19 10 50                                 |                             |                       |  |  |
| 10-21  |                  | 30. Name and address of person who co  | impleted cause of death (Item   | п 23а) (Туре,         | Print)                                 | 2 -                                       | 11 -  |   |                             |                       |  |  |
| 1711   |                  | C. TiMOTHY   | DESSEY:   | MO                    | -                                      | 71, NO36                                  | an El   | ,   |                             |                       |  |  |
| Sta<br>Registr   | - 4              | 31. Date filed (Month, Day, Year)  | 32. Reģistrar's Sign.   | A A                   | and a                                  |   |   |   |                             |                       |  |  |

| 1 | - | For<br>State<br>Registra | • |
|---|---|--------------------------|---|
| 4 |   |                          |   |

State of Maryland / Department of Health and Mental Hygiene 15

41534

|  |  |                             | Registrar   |  |                                       | C                           | ertificat   | e or   | Deam  | 1                 |                                | Reg. No   |                                   |                   | 71004  |
|--|--|-----------------------------|---|--|---------------------------------------|-----------------------------|---|--|---|-------------------|--------------------------------|---|-----------------------------------|-------------------|--|
|  | hysicia<br>/Medic  |                             |   | George   |                                       | iid, Jr                     | •   |  |   |                   |                                | er 2  |                                   |                   | 3. Time of Death 10:30 a.m.                            |
|  | xamin  |                             | 4a. Facility Name (If not institution, give street and number) Manor Care Ruxton  |  |                                       |                             |   | 4b. City, Town, or Location of Death TOWSON  |   |                   |                                | 4c. County of Death<br>Baltimore  |                                   |                   | е  |
|  | neral<br>ector   |                             | 152-22-0595   | Бөх<br>1 <b>Д</b> М 2□ F                                     | 7. Age (In )                          | rs. last birthda<br>Yrs.    | y) If Unde<br>Months  | Days   | If Under<br>Hours   | r 24 Hrs.<br>Min. | 8. Date of B<br>DeC.           | irth<br>Pay, Year)  | 931                               | 9. Birth          | place (State or Foreig<br>Primersey                    |
| is 1 and 2 should be filed within 72 hours after death with the Maryland is 1 and 2 should be filed within 72 hours after death with the Maryland if the thin and Mental Hygiene.  Other traumatic event. It a Medical Francia must be notified at | tor  | Usual Residence of Decedent | ate 10b. County 10c. City, Town or I  |  |                                       |                             |   |  |   |                   |                                | 10d. Inside   |                                   |                   |  |
|  | 3a or 28   | i Director                  | 10e. Street and Number<br>47 Washin   | gton Rd  |                                       |                             |   | 10f. Zip Code<br>17349   |   |                   |                                | 10g. Cit  | 10g. Citizen of What Country? USA |                   |  |
|  | at', or items 2  | by Funerai                  | 11. Marital Status  1 Never Married X Married 3 Widowed 4 Divorced  | 12. Was Dec<br>Armed Fo<br>1 XYes<br>If Yes, Gi<br>Year or D | edent Ever i<br>orces?<br>2 No<br>ive | n U.S. 13                   |   | Was Decedent of Hispanic Origin? (Specify Ye If Yes, specify Cuban, Mexican, Puerto Rican, 1 ☐ Yes 2 ☐ No Specify: |   |                   | ecify Yes or N<br>Rican, etc.) | No- 14. Race - American Indian,<br>Black, White, etc.<br>Specify: White |                                   |                   | , etc.   |
| within 72 ho   | than "natur<br>the Medical   | Completed                   | 15. Decedent's E<br>(Specify only highest gr<br>Elementary/Secondary (0-12)   | ade completed)   | 1-4or 5+)                             | (Gi                         | edent's Usual Occupation<br>re kind of work done during most of working<br>DO NOT use retired)<br>1 y s t |  |   |                   |                                | 16b. Kind of Business/Industry  Market Research                         |                                   |                   |  |
| uld be filed   | rked other<br>tic event.   | To Be C                     | 17. Father's Name (First, Middle, Las Timothy G. McQu   |  | •                                     |                             |   |  | 18. Moth  | enie              | (First, Middle<br>Ellir        | le, Maiden<br>ngham   | Sumam                             | θ)                |  |
| Definitions, wally permit. Pages 1 and 2 shou Department of Health and Mimportant: If Item 27 is mart any injury or other traumations.   | or trauma  |                             | 19a. Informant's Name/Relationship (Type, Print)  Mrs. Elinor McQuaid/ Wife  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, 2 47 Washington Rd. New Freedom, Pa. 173   |  |                                       |                             |   |  |   |                   |                                |   |                                   |                   |  |
|  | ant: if iten<br>ury or oth   |                             |   |  |                                       |                             |   | Service Co. 12-29-05   |   |                   |                                |   | Towson, Md.                       |                   |  |
| permit.<br>Depart  | any inj<br>2008.   |                             | 21. Signature of Furieral Service Lice  | nsee   | }                                     |                             | 22. Name a<br>RUC   | nd Addre   | ss of Facil   | Funer             | al Hor                         | me, I   | nc                                |                   |  |
| /Me<br>Exam  | inding physician and call in a set as the burial-transit as the burial-transit as the burial transit as the bu | icai Examiner               | shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last  | a. Due to  | ARC. (or as a con                     | sequence of): sequence of): | 1 8   | ' 2  | 50 p  | ohag              | nis                            |   |                                   |                   | Interval Between Onset and Death                       |
| the death certification  | / the attending pl<br>ched for use as t  | Physician/Medical           | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown   |  | birth 2 🗔 l<br>nant at time           | etal death                  | 3 ⊟Ectopic p<br>5 ⊟ Other (s  |  | 2. Date of Death December 20, 2005  m, or Location of Death nor Month Poech Baltimore  Bar It Under 24 Hrs. S. Date of Birth Baltimore  Bar It Under 24 Hrs. S. Date of Birth Baltimore  Bar It Under 24 Hrs. S. Date of Birth Baltimore  Bays Hours Min Dec. 100  100  101  102  103  104  105  105  106  107  107  108  109  109  109  109  109  109  109 | very<br>Day Year  |                                |   |                                   |                   |  |
| The law requires that the death  | been signed by the atte<br>should be detached for  | by                          | 1   |  |                                       |                             |   |  |   |                   |                                |   |                                   |                   |  |
|  | ate has<br>page 2  | Completed                   | Diale   | Fes M  | relli                                 | Tus.                        |   |  |   |                   | aut<br>per                     | opsy<br>formed?   | d                                 | leath?            | opsy findings availab<br>ompletion of cause of<br>2 No |
| vital<br>ician:  | director.  | Be                          | 25. Was case referred to medical examiner?  |  |                                       |                             |   |  |   |                   |                                |   |                                   |                   |  |
| ding Phy<br>h.<br>After this<br>funeral d  | this c   | ပ                           | 1 ☐ Yes 2 No  |  |                                       |                             | Nursing Home 5 Hesidence 6 Uniter (Specify)   |  |   |                   |                                |   | fy)                               |                   |  |
|  | After  | Certification:              | 27. Manner of Death  1 Natural 5 Pending 2 Accident investigate 3 Suicide 6 Could not   | on   | of Injury<br>nth, Day Yea             | z) 28b. Time                |   | Work?  |   |                   |                                | e how inju  |                                   |                   |  |
| To the Hospital or Attending within 24 hours after death.  | ral Director:<br>led in by the   | Certific                    | 4 Homicide determined   | 289. Plac<br>build   | ding, etc. (Sp                        |                             |   |  |   |                   | City or T                      | own, State  | θ)                                |                   |  |
| he Hosp<br>in 24 hou   | To the Funer<br>completely fil   | Medical                     | 29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  |                                       |                             |   |  |   |                   |                                |   | to the cause(s)                   |                   |  |
| To t.<br>withi   | To t   | Σ                           | 29b. Signature and title of certifier   | Elnels   | 1                                     |                             | 29  | C. Licens  | e number  | 284               | ig                             | 29d. Da   | te signed                         | 1 (Month,<br>20 - | Day, Year)   |
| io:  | iotl   |                             | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  AH. GHILADI. MD. 7600 OSLER DV. TOWSON MD 21204   |  |                                       |                             |   |  |   |                   |                                |   |                                   |                   |  |
| 10   | Sta  |                             | 31. Date filed (Month, Day, Year)   |  | Registrar's S                         |                             |   |  |   |                   |                                | -01   |                                   |                   |  |

DHMH 17 Rev 1/2001

Registrar

|   |                  | Please Type or Print in Blace State of Maryland /  | / Depa  |  | lealth and N   | Mental Hyg                                    | iene  | 1.1535   |  |  |  |
|---|------------------|--|---|--|--|---|---|--|--|--|--|
| Physic  |                  | Registrar     Decedent's Name (First, Middle, Last)     Tyrone Moore   | 0671  | incate or i  | Deam   | 2. Date of Death<br>Month<br>Dec.             | Day Year<br>16 200                          |  |  |  |  |
| /Med<br>Exami   |                  | 4a. Facility Name (If not institution, give street and number) Stella Maris Hospice  |   | 4b. City, Town, o  | Location of Death                                      |   | 4c. County of Dea<br>Baltimo                | ath  |  |  |  |
| Funeral<br>Director   |                  | 5. Social Security Number 218-64-4667 6. Sex 1 $\mathbb{X}^{\text{M}}$ 2 $\mathbb{Z}$ 7. Age (In yrs. last to 259)   | birthday)<br>Yrs.   | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.                         | 8. Date of Birth (Month, Day, 12-9-4          | Year) C                                     | nthplace (State or Foreign<br>country)<br>MD                         |  |  |  |
| aryland<br>•how   | or               | Usual Residence of Decedent  10a. State 10b. County 10c. City, To Balt.  |   |  |  |   |   | 10d. Inside City Limits XIXYes 2 □ No                                |  |  |  |
| vith the A  | Director         | 10e. Street and Number<br>1710 E. 25th Street  |   | 10f. Zip Code  |  |   | 0g. Citizen of What C                       | ountry?  |  |  |  |
| IOTE, Maryland ZIZIS-UU30 ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. it if tem 27 is marked other then "natural", or iteme 23a or 28a-1 show or other traumatic event, the Madical Examiner must be notified at | by Funeral       | 11. Marital Status  1 Never Married 2 Married 3 Widowed *Divorced  12. Was Decedent Ever in U.S. Amed Forces? 1 Yes, Sive 1 Yes, Give 1 Year or Dates:   |   | 21213  /as Decedent of H Yes, specify Cuba  □ Yes 2X No  | ispanic Origin? (Sp<br>In, Mexican, Puerto<br>Specify: |   | J.S.A.  14. Race - Am Black, Wh Specify: B] | ite, etc.  |  |  |  |
| Maryiathd ZIZIS-UUSO<br>td 2 should be filed within 72 hours af<br>th and Mental Hygiene.<br>27 is marked other then "natural", or<br>traumatic event, the Medical Exam   | Completed to     | 15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)   | (Give k<br>life. D  | O NOT use retired  | during most of work<br>f)                              | ang   | 16b. Kind of Business                       |  |  |  |  |
| nd Z<br>be filed v<br>al Hygie<br>d other   | Be Co            | 17. Father's Name (First, Middle, Last)  | anıt  | ation W  | 18. Mother's Nam                                       | e (First, Middle, N                           | Public So<br>Maiden Surname)                | chool  |  |  |  |
| aryland<br>should be and Mental I   | 10               | Robert Lee Moore  19a. Informant's Name/Relationship (Type, Print)  19   | 9b. Mailing   |  | Louise   |   | City or Town, State,                        | Zip Code)  |  |  |  |
| Te, Mis<br>1 and 2<br>Health a<br>1em 27 is<br>other trau   |                  | Stella Armstrong (sister) 1606 Cliftview Ave. Balto. MD 21213  |   |  |  |   |   |  |  |  |  |
| SAITIMOTE,  bermit. Pages 1 ar  bepartment of Hea  mportant: if item;  ny injury or other  mee.   |                  | 20a. Method of Disposition  1 ABurial 2 Cremation 3 Removal from State  4 Donation 5 Other (Specify)  20b. Place of Disposition (Name of cemetery, crematory or other place)  Sacred Heart  12-21-05  Dundalk, MD  |   |  |  |   |   |  |  |  |  |
| Dailtimore, permit. Pages 1 and Department of Healt important: if item 2 eny injury or other once.  |                  | 21. Signature of Funeral Service Licensee  |   |  |  |   | avis Jr.<br>o. MD 21                        |  |  |  |  |
| T SA  |                  | 23a. Pant. Enter the disease for complications that caused the death. Di shock, or heart failure, List only one cause on each line.  |   |  |  |   |   | Approximate<br>Interval Between                                      |  |  |  |
| Physician<br>/Medical<br>Examiner   |                  | Immediate Cause (Final disease or condition resulting in death)  a. HEAD AND NECK Due to (or as a consequence Sequentially list conditions,  | ce of):   | ER   |  |   |   | Onset and Death  |  |  |  |
| icate be executed physician and streets the burial-transit  | ical Examiner    | Sequentially list conditions, 1 any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated avents resulting in death) Last  b. Due to (or as a consequence of the consequenc |   |  |  |   |   |  |  |  |  |
| Attending Physicien: The law requires that the death certificate I death.  death. ector: After this certificate has been signed by the attending physic yie funeral director, page 2 should be detached for use as the t  | Physician/Medica | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown  23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) Month   |   |  |  |   |   |  |  |  |  |
| w requires that been signed be should be deta   | þ                | Part II. Other significant conditions contributing to death but not resulting  | g in the und  | derlying cause giv   | en in Part I.  |   | acco use contribute t                       | o the cause of death?  |  |  |  |
| UNISION OT VITAL MECONGS,  I or Attending Physicien: The law requires th after death.  Director: After this certificate has been signe i in by the funeral director, page 2 should be d   | Completed        |  |   |  |  | 24a. Was ar<br>autopsy<br>perform<br>1 Tyes 2 | prior to death?                             | utopsy findings available completion of cause of s 2 \( \text{No} \) |  |  |  |
| OI VILLAI F<br>Physicien: Th<br>this certificate<br>al director, pag  | To Be            | 25. Was case referred to medical systeminer?  1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/C  | Outpatient  | 3□ DOA Oth   |  | h Check only one                              | nce 6 <b>√2</b> Other <i>(Spe</i>           | ocify) HOSPICE   |  |  |  |
| SION O  | Certification; 1 | 1 ★ Natural 5 Pending (Month, Day Year) investigation  | b. Time of<br>Injury  |  | -  | 28d. Describe ho                              | w injury occurred                           |  |  |  |  |
| DIVISION OF VILSI HER WITH TO the Hospital or Attending Physicien: The la within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2  | Certifi          | 4 Homicide determined 28e. Place of Injury - At home, building, etc. (Specify)   | , farm, stre  | reet, factory, office  28f. Location (Street and Number or Rural Route Number City or Town, State) |  |   |   |  |  |  |  |
|   | Medical          | 29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  Check only one)  Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |   |  |  |   |   |  |  |  |  |
|   | Me               | 29b. Signature and title of certifier  | 29c. License number 29d. Date signed (Month, Day, Year)  12/16/05 |  |  |   |   |  |  |  |  |
| 5   |                  | 30. Name and address of person who completed cause of death (Item 23a  |   |  | J. 01  | 100 0 C C                                     | , ,   | ,  |  |  |  |
|   | tate             | DR. TARIQ MAHMOOD 2300 DULANEY  31. Date filed (Month, Day, Year)  32. Registrar's Signature   | •   |  | IMONIUM,   | MU 2109;                                      | 3   |  |  |  |  |
| DHMH 17 Rev 1/  | -5               | DEC 2 3 2005   | - S.                          | 34/1   | · · · · · · · · · · · · · · · · · · ·                  |   |   |  |  |  |  |
|   |                  | C  | ORIGIN  | AL   |  |   |   |  |  |  |  |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) m C Donald Month Year **Physician** naue December 22, 205 1.00.4 M /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner - Homewood NIA utule Care Da more If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, May 10 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2 XF 218-10-7076 Director nari Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits If item 27 le marked other than "natural", or items 23s or 28s-1 show or other traumatic event. The Modical Examinar must be excitited at 12 405 2 No by Funeral Director 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 2121 USI 2700 Race - American Indian, Black, White, etc. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status e filed within 72 hours after at Hygiene. other than "natural", or Ite Yes 2 No f Yes, Give Year or Dates: 1 Never Married 2 Married Black Baltimore, Maryland 21215-0036 1 Yes 2 No 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry BAR Elementary/Secondary (0-12) College (1-4or 5+) ork 12-th NIA 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Pages 1 and 2 should be fill iment of Health and Mental H lant: If Item 27 Is marked other inknow unknown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 3925 W. mulberrylt. Dillard - Grandson Dalto. ma. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1, Qurial 2 ☐ Cremation 3 ☐ Removal from State Department of time of time of time of the time of the time of Com. 10 dS 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Furieral Service Licensee 22. Name and Address of Facility dHIL Dueto, md, 21224 or emplications that caused the death. Do not enter the mide of dying, such as cardiac or respiratory arrest 1P, march reneral Home 23a. Part 1 the discase, or complications that caused the shock, in a rt failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate C se (Final disease or condition resulting in death) End Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to or as a consequence of) Examine attending physician and for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No cete has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 4 NUnknown au 1 ☐ Yes 2 ☐ No 3 Probably Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 19 No 1 ☐ Yes 2 12 No 1 ☐ Yes or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 12 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 1 Natural Injury 5 Pending within 24 hours after death.

To the Funeral Director: Af 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 🔲 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicai 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Registrar DHMH 17 Rev 1/2001

State

1600 W. MOUNT

istrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month :40 AM McGanagar 2005 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death University MD Medical Baltimore 0 Center N/A Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Y Oct. 15, Birthplace (State or Foreign Country) Days Min Hours 1 🛣 M 2 🗆 F 209 16 3679 80 Pennsylvania 1925 Usual Residence of Deceden 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Anne Arundel Baltimore 1 ☐ Yes 2X No Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S. 4106 Ritchie Highway 21225 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No Was Decedent of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Bace - American Indian Black, White, etc. 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 No If Yes Give Specify: WW II 3 Widowed 4 □ Divorced Year or Dates: 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Cottege (1-4or 5+) Police Officer Baltimore City 8th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) John F. McGahagan, Sr. Mary Barbara Petrushak 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 331 Penshurst Place Mary Kauffman / Daughter Chesterfield, Missouri 63017 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Holy Cross Cemetery Baltimore, Maryland 12/26/2005 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Gonce Funeral Service, P.A. m 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 4001 Ritchie Highway Baltimore, Maryland 21225 Approximate Interval Between Onset and Death Immediate Cause (Final Myocar dial disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) IF FEMALE 23c. tf yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Probably 1 ☐ Yes 2 ☐ No 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1 Yes 25. Was case referred to medicat examiner? 26. Place of Death (Check only one) ≥X No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Inpatient 1 🗌 Yes 3□ DOA 2 ER/Outpatient Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Natural 1 Tes 2 No 2 Accident 6 Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homicide

The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, the attending physicien as the esn ō be detached been signed by page 2 should has certificete Hospital or Attending Physician: filled in by the funeral director, this After death. after death within 24 hours a To the Funaral I completely

Physician

/Medical

Examiner

**Funeral** 

Director

or 28a-f show

Director

Funeral

Completed by

Be

2

SDC.

Examiner

by Physician/Medical

Completed

Be

Certification: To

Medical

**Physician** 

/Medical

Examiner

item 27 ie marked other than "natural", or iteme 23a or 28a-f ehov other treumatic event, the Madical Examinar must be notitled at

permit. Pages 1 and 2 should be filed within 72 hours after to Deperment of Health and Mental Hygiene important; if item 27 is marked other than "natural", or itement on july or other traumate.

Baltimore, Maryland 21215-0036

with the Maryland

death v

DHMH 17 Rev 1/2001

2

State Registrar

29a. Certifier

(Check only one)

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) tham Angela. 31. Date filed (Month, Day, Year) 3 DEC 2 2005



22 S. Greene Street

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

6/11

29d. Date signed (Month, Day, Year)

Baltimore, Maryland 21201

| hysician                           |     | State RegistrAmend Item  1. Decedent's Name (First, Middle,  | Last)   |  |                |   |                     | 2. Date of Do<br>Month   | Day                           | Year                     | 3. Time of Death                                 |
|------------------------------------|-----|--|---|--|----------------|---|---------------------|--|-------------------------------|--------------------------|--|
| /Medical                           |     | ISAAK  |   |  |                | MALYKIN                                 | -1                  | DECEME   |                               | 2005                     | 4:32 A   |
| xaminer                            | 1   | Ia. Facility Name (If not institution,<br>6994 MILBROOK  |   |  | ١              |   | or Location of Deat | ın   | 4c. County                    |                          | 4ODE   |
| ineral                             | 5   |  |   | APT.2 <i>-1</i><br>je ( <i>In yr</i> s. last |                | If Under 1 Year                         | If Under 24 Hrs     |  | rth                           | ALTIN<br>9. Bjrth        | TURE<br>plac <b>Belarus</b> 9                    |
| ector                              |     | 220-25-9080  | 1 M 2 □ F   | 72   | Yrs.           | Months Days                             | Hours Min           | 01727  | 71933                         | Соц                      | BELORUS  |
|                                    | -   | Usual Residence of Decedent  10a, State 10b, County  |   | 10c. City, T                                 | own or Lo      | cation                                  |                     |  |                               |                          | 10d. Inside City Limits                          |
| other must be notified at          |     |  | TIMORE  |  | IMOR           |   |                     |  |                               |                          | 1 ☐ Yes 2 ☐ No                                   |
| Director                           | -   | 10e. Street and Number   | TIPONE  | DALI   | THON           | 10f. Zip Code                           |                     |  | 10g. Citizen of               | What Cou                 | ntry?  |
| ad la                              |     | 6994 MILBROOK  | PARK DR. AF   | PT.2-A                                       |                | 21215                                   |                     |  | U.S.A                         |                          |  |
| for must                           |     | 11. Marital Status   | 12. Was Decedent<br>Armed Forces  | Ever in U.S.                                 | 13.            | Was Decedent of H                       | Hispanic Origin? (S | Specify Yes or Note (Note (Not | o- 14. Rac                    | ce - Ameri<br>ck. White. | can Indian,                                      |
| 3 5                                | 2   | 1 ☐ Never Married ★★ Marrie<br>3 ☐ Widowed 4 ☐ Divorced  | Armed Forces od 1 Tyes 2 1 Tyes, Give Year or Dates:                    | No .   | í              | 1□Yes 2X No                             |                     | ,  |                               | y: WH]                   |  |
| dical                              |     | 15. Decedent'<br>(Specify only highest   |   | 1  | (Give          | tent's Usual Occur<br>kind of work done | during most of wo   | rking  | 16b. Kind of B                | usiness/ir               | ndustry  |
| other traumatic event, the Madigal |     | Elementary/Secondary (0-12)  | College (1-4or  | 5+)  | MECH           | DO NOT use retire<br>ANTC               | 0)                  |  | FACTOR                        | Y FOI                    | ITPMFNT  |
| CO                                 |     | 17. Father's Name (First, Middle, L  | ast)  |  | 112011         | 71110                                   | 18. Mother's Na     | me (First, Middle  | , Maiden Sumar                |                          | 711112111  |
| To Be                              | í   | SOLOMON  |   | МΔΙ  | YKIN           |   | GENYA               |  |                               |                          | CAPELYAN   |
| 1                                  |     | 19a. Informant's Name/Relationsh   | ip (Type, Print)  |  |                | ng Address (Street                      |                     | ural Route Numb  | oer, City or Town             |                          |  |
|                                    |     | BASYA MALYKIN /  | WIFE  |  | 6994           | MILBROOM                                | K PARK DI           | R. APT.2   | -A BALTI                      | MORE                     | ,MD 21215  |
|                                    | 1   | 20a. Method of Disposition 1 Ø Burial 2 ☐ Cremation  | 2 □Removal from State   | ceme   | etery, crei    | sition (Name of<br>matory or other pla  |                     | Date   | 20c. Location                 |                          |  |
| lary or                            |     | 4 □Donation 5 □Other (Sp   |   | BALTI  |                | HEBREW                                  |                     |  | REISTER:                      |                          |  |
| DUC.                               | Т   | 21. Signature of Finceral Service L  | icensee   |  |                | Name and Addre                          |                     |  |                               |                          |  |
| a                                  | 1   | 23a. Part1 Enter the disease, or o   |   |  |                |   |                     |  |                               | LLC,                     | MD 21208 Approximate                             |
| ian<br>ical<br>ner                 |     | Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions if any, leading to immediate | b   | a consequent                                 |                | May of                                  | ARREST              |  |                               | /                        | Onset and Death                                  |
| Examiner                           |     | cause. Enter Underlying<br>Cause (Disease or injury<br>that initiated events<br>resulting in death) Last                   | c. Due to (or as  | a consequen                                  | ce of):        |   |                     |  |                               |                          |  |
| Medical Examir                     | 3   |  | d   |  |                |   |                     |  |                               | -                        |  |
| Physician/Med                      |     | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown                                    | 23c. If yes, outcome<br>1 □ Live birth<br>4 □ Pregnant a<br>9 □ Unknown | 2 Fetal de                                   | ath 3          | Ectopic pregnanc Other (specify)        | у                   |  |                               | ate of delive            | ery<br>Day Year                                  |
| 2                                  | 2   | Part II. Other significant condition   | _   | out not resultin                             | ng in the u    | nderlying cause gr                      | ven in Part I.      |  | tobacco use con<br>Yes 2 □ No | tribute to t             | the cause of death?                              |
| ompieted                           |     |  |   |  |                |   |                     |  | psy                           | Were auto                | opsy findings available<br>ompletion of cause of |
| Com                                | ) _ | 25. Was case referred to medical   |   |  |                |   | OS Plane of Do      | 1 ☐ Yes  |                               | 1 🗌 Yes                  | 2□ No  |
| B                                  | 3   | examiner?  | Hospital:   | ent 2∏ER                                     | /Outpatier     | nt 3□ DOA Ott                           | her: 4 Nursing      | 1/   | idence 6 □Oth                 | ner (Sneci               | fv)  |
| 1-                                 | 11  | 27. Magner of D th   | 28a. Date of Inj  | ury 28                                       | b. Time o      |   |                     | 1  | how injury occur              |                          | 71   |
| atio                               | 2   | 1 Natural 5 Pending investig   | ation   | 47 10011                                     | ицигу          |   | rk?<br>]Yes 2 □No   |  |                               |                          |  |
| Certification                      |     | /3 Suicide 6 Could n 4 Homicide determi  | ned 289. Place of in  | jury - At home<br>tc. (Specify)              | , farm, str    | eet, factory, office                    |                     | 28f. Location<br>City or To  | (Street and Numb              | ber or Run               | al Route Number,                                 |
|                                    |     | SOL CONTROL  |   |  |                |   |                     | 1  |                               |                          |  |
| la cipa                            | 2   | 29a. Certifier 1 Certifying (Check only one) 2 Medical E   | p Physician: To the besi<br>examiner: On the basis<br>and manner s      | of avamination                               | and/or in      | vestigation in my                       | aninian death ago   | urrod at the time  | date and place                | and dup t                | o the cauco(c)                                   |
| Medical Certification              |     | 29b. Signature and title of certifier  | . 0   |  |                | 29c. Licens                             | se number           |  | 29d. Date signe               | d (Month,                | Day, Year)                                       |
|                                    |     | 1.1  | 14 ru   |  |                | n2                                      | 5039                |  | 12/2                          | LVO                      | 5  |
| 1                                  |     | 30. Name and a press of pers in  |   | death (Item 23                               | Ba) (Type,     | 29c. Licen: Dr. Print                   | 1 -                 | 1.4-   | 10                            | 4/10                     | 1200   |
|                                    | ľ   |  | OBOUTT A  | w, '2  | 835            | Junty                                   | HVE,                | DITUTION   | DIL                           | יט נ                     | 1 407  |
| State<br>Registrar                 |     | 31. Date filed (Month, Day, Year) DFC 2 3 2  | 005 Regist  | rar's Signature                              | Proper         | 32.0                                    | /                   |  |                               |                          |  |
| - Short ell                        |     | 115000   | UUU AMMAN   | of the                                       | Carried Street | White.                                  |                     |  |                               |                          |  |

|                   |   | •                   | 1 - For State of Maryland / Department of Mary | artment of F<br>rtificate of                                |                              | nd Mental Hy                                | ygiene<br>Reg/No.005                                 | 41539  |  |  |  |  |
|-------------------|---|---------------------|--|---|------------------------------|---|--|--|--|--|--|--|
|                   | Physicia<br>/Medic  |                     | 1. Decedent's Name (First, Middle, Last)<br>Rebecca Rena Nelson  |   |                              | 2. Date of D<br>Month<br>Dec.               | 17 2005 Year   | 3. Time of Death  1:25 P.M                       |  |  |  |  |
|                   | Examin  | er                  | 4a. Facility Name (If not institution, give street and number) 5246 Nelson Avenue  | 4b. City, Town, o   |                              | Death                                       | 4c. County of Dea                                    | ith  |  |  |  |  |
|                   | Funeral   | 3.9                 | 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)  | If Under 1 Year   | If Under 24                  |   | irth 9. Bi   | thplace (State or Foreign                        |  |  |  |  |
|                   | Director  |                     | 216-34-3383 1 M X F 68 Yrs.  | Months Days   | Hours                        | Min. (Month, D                              |  | ountry)<br>.Carolina                             |  |  |  |  |
|                   | bne w   |                     | Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Lo  | ocation   |                              | -   |  | 10d. Inside City Limits                          |  |  |  |  |
|                   | Maryl   | ro                  | Maryland N/A Balti   |   |                              |   |  | U∏Yes 2 No                                       |  |  |  |  |
|                   | r 28a   | lrec                | 10e. Street and Number   | 10f. Zip Code   |                              |   | 10g. Citizen of What C                               | ountry?  |  |  |  |  |
|                   | 238 c   | raiD                | 5246 Nelson Avenue   | 2121  | 5                            |   | USA  |  |  |  |  |  |
| 36                | permit. Pages 1 and 2 should be filed within 72 hours efter death with the Marylend Department of Health and Mental Hygiene. Important: If Iem 27 is marked other than "natural", or Items 23a or 28a-f ahow any injury or other traumatic event, I're Medical Evaluinar man be notified at ance. | by Funeral Director | 1 Never Married 2 Married 1 Yes 2X No  | Was Decedent of H<br>If Yes, specify Cuba<br>1 ☐ Yes 2 2 No |                              | n? (Specify Yes or N<br>Puerto Rican, etc.) | 14. Race - Am<br>Black, Whi<br>Specify: B1           | te, etc.   |  |  |  |  |
| 5-0036            | 72 hou  |                     | 15. Decedent's Education 16a. Dece (Specify only highest grade completed) (Give  | edent's Usual Occup<br>kind of work done                    | oation                       | d working                                   | 16b. Kind of Business                                | s/Industry                                       |  |  |  |  |
| 2121              | iffin 7   | Completed           | Elementary/Secondary (0-12) College (1-4or 5+)   | DO NOT use retire   | d)                           | ii working                                  | Levindale  | Nursing  |  |  |  |  |
| 2                 | Hygier<br>Hygier<br>Sthertl   | CO                  | 2 Years LPN 17. Father's Name (First, Middle, Last)  |   | 18. Mother's                 | Name (First Middle                          | Home  e, Maiden Sumame)                              |  |  |  |  |  |
| Maryland          | should be<br>nd Mental<br>marked o  | To Be               | Alexander Chandler   |   |                              | Jenkins                                     |  |  |  |  |  |  |
| ary               | 2 shou<br>and M<br>Is mar   |                     | 19a. Informant's Name/Relationship (Type, Print) 19b. Maili  | ing Address (Street   | and Number                   | or Rural Route Numi                         | ber, City or Town, State,                            | Zip Code)  |  |  |  |  |
|                   | 1 and 2<br>Health<br>tem 27 I   |                     |  | immions   | ₹£.                          | Lynchbur                                    | g, Sc. 29<br>20c. Location - City o                  | 080  |  |  |  |  |
| nore              | Pages 1<br>nent of H<br>int: If Ite<br>iry or ott   | 1                   | XI Buriai 2 Cremation 3 Linemoval from State V: nor Mo   | matory or other pla   | ce) '                        |   |  |  |  |  |  |  |
| Baltimore,        | permit. P<br>Departme<br>Importsn<br>any injur  |                     | King Memorial Park 12/23/05 Woodlawn, Mar  21. Signature of Funeral Service Livensee  22. Name and Address of Facility Chatman—Harris Funeral  5240 Reisterstown Rd Baltimore, Md 21   |   |                              |   |  |  |  |  |  |  |
|                   | <u>.</u>  |                     | 23a. Part. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.   |   |                              |   |  | Approximate<br>Interval Between                  |  |  |  |  |
| 1                 | Physician   |                     | Immediate Cause (Final disease or condition Coronary AC  | tery O  | iseasi                       | e/Myaco                                     | laila  | Onset and Death                                  |  |  |  |  |
| 140               | /Medical<br>Examiner  |                     | Due to (or as a consequence of):   | , )   |                              | 7.3   | Infarction   | Years  |  |  |  |  |
| 12/20             | The second second   | er                  | Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):   | nysen   | ()                           |   |  | 7041   |  |  |  |  |
| 1/                | cuted<br>od<br>ransit   | Examiner            | Cause, Enter Underlying Cause (Disease or injury that initiated events  c. End Stage   | Kenal   | Ois                          | sease                                       |  | Years .  |  |  |  |  |
| 8760,<            | ate be executed hysicien and the burial-transit   |                     | resulting in death) Last Due to (or as a consequence of):  |   |                              |   |  |  |  |  |  |  |
| 3876              | cate t  | dlcal               | d  |   |                              |   |  |  |  |  |  |  |
| Box 6             | nding<br>use as   | n/Me                | IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy  | <b>-</b>  |                              |   | 23d. Date of de                                      | livery   |  |  |  |  |
| P.O. B            | it the death certific<br>by the attending p<br>tached for use as  | Physician/Med       | in the past 12 months?   | □Ectopic pregnancy □ Other (specify) _                      | у                            |   | Month  | Day Year   |  |  |  |  |
|                   | Attending Physician: The law requires that the death certificate be executed rideath. rideath. ector: Atter this certificate has been signed by the attending physicien and by the funeral director, page 2 should be detached for use as the burial-transit.                                     | by                  | Part II. Other significant conditions contributing to death but not resulting in the u   | anderlying cause giv  | ven in Part I.               |   | tobacco use contribute to                            | o the cause of death? robably 4 Unknown          |  |  |  |  |
| Records,          | Physicien: The law re<br>this certificate has be<br>rat director, page 2 sh   | Completed           |  |   |                              | 24a. Wa<br>auto<br>peri<br>1 🗆 Yes          | opsy prior to death?                                 | utopsy findings available completion of cause of |  |  |  |  |
| /ita              | cian:<br>ertific<br>actor,  | Be                  | 25. Was case referred to medical examiner?   | /   |                              | f Death (Check only                         | опе)   |  |  |  |  |  |
| of                | Physi<br>this c   | To:                 | 1  | INT STEP DOA  |                              |   | sidence 6 Other (Spendar)                            | ecify)   |  |  |  |  |
| 0                 | ding F<br>th.<br>After<br>funera  | tlon                | 27. Manner of Death  1 Natural 5 Pending (Month, Day Year)  2 Accident investigation   | Wo  | rk?<br>]Yes 2.∐No            |   | now injury occurred                                  |  |  |  |  |  |
| Division of Vital | i i i i   | Certification;      | 3   Suicide 4   Homicide  6   Could not be determined  28e. Place of Injury - At home, farm, st building, etc. (Specify)   | reet, factory, office                                       |                              |   | (Street and Number or Rown, State)                   | lural Route Number,                              |  |  |  |  |
|                   | To the Hospital within 24 hours a To the Funerat Completely filled  | Medical C           | 29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, deat 2 Medical Examiner: On the basis of examination and/or in and manner stated.  | th occurred at the til                                      | me, date and popinion, death | place, and due to the occurred at the time  | e cause(s) and manner a<br>e, date and place, and du | s stated.<br>e to the cause(s)                   |  |  |  |  |
|                   | To the To the comp  | ×                   | 29b. Signature and title of certifier  | 29c. Licens   |                              | 7.7 0                                       | 29d. Date signed (Mon                                | th, Day, Year)                                   |  |  |  |  |
| )                 |   |                     | Milling you  |   | 254                          |   | 14/20  |  |  |  |  |  |
|                   | 3   |                     | 30. Name and address of person who completed cause of death (Item 23a) (Type, William Yu, MD Z405 York  31. Date filed (Month, Day, Year)  32. Reistrar's Signature  | Print) Road   | ,#/c                         | 00, T.                                      | monium,  | MO 21093   |  |  |  |  |
|                   | Sta<br>Registi  |                     | 31. Date filed (Month, Day, Year)  DEC 2 3 2005  32. Registrar's Signature   | Cast's  |                              |   |  |  |  |  |  |  |

DHMH 17 Rev 1/2001

ORIGINAL

DHMH 17 Rev 1/2001

DECEMBER 19,

TERONICA NUESLEIN

|                   |   |                | _ FOr  | State of Maryland   |                    |   |               | nd Mental Hyg                                 | iene                                 | 1.1511                             |
|-------------------|---|----------------|--|---|--------------------|---|---------------|---|--------------------------------------|------------------------------------|
|                   |   |                | 1 - State<br>Registrar   |   | Cer                | tificate of L   | <i>Death</i>  | 2. Date of Deat                               | eg. No. UUU                          | 41041                              |
|                   | Physicia  | an             | 1. Decedent's Name (First, Middle, Last)  Deborah Ann Pater  | sabie   |                    |   |               | Decembe                                       | Day Year                             | 3. Time of Death 6:50 P M          |
|                   | /Medic  | al             | 4a. Facility Name (If not institution, give st   |   |                    | 4b. City. Town, or  | Location of C |   | 4c. County of Deat                   | l <u>.</u>                         |
| Е                 | Examin  | er             | 1716 Greenspring   |   |                    |   | vensor        |   | _                                    | imore                              |
|                   | Funeral   |                | 5. Social Security Number 6. Sex   | 7. Age (In yrs. las                                       | t birthday)        | If Under 1 Year   | If Under 24   | Hrs. 8. Date of Birth                         | 9. Birt                              | nplace (State or Foreign<br>untry) |
|                   | Director  |                | 218-70-8868  | <sup>M 2⊠F</sup> 48                                       | Yrs.               | Months Days   | nouis         | May 26,                                       | 1957 Mar                             | ÿľánd                              |
|                   | pur *   |                | Usual Residence of Decedent  10a. State 10b. County  | 10c. City.  | Town or Lo         | cation  |               |   |                                      | 10d. Inside City Limits            |
|                   | Maryli<br>sho   | ō              | Maryland Baltimor  |   | _                  | venson  |               |   |                                      | 1 ☐ Yes 2X No                      |
|                   | the h   | Directo        | 10e. Street and Number   | . 5   | J 16               | 10f. Zip Code   |               | 1   | 0g. Citizen of What Co               | untry?                             |
|                   | 3e or   | io le          | 1716 Greenspring V   | /allev Road   |                    | 211   | 53            |   | USA                                  |                                    |
|                   | death   | Funeral        |  | Was Decedent Ever in U.S.<br>Armed Forces?                | 13.                | Vas Decedent of His   | spanic Origin | n? (Specify Yes or No-<br>Puerto Rican, etc.) | 14. Race - Ame<br>Black, White       |                                    |
| õ                 | or ite  | Fu             | 1 Never Married 2 Married  | 1 ☐ Yes 2√ No<br>If Yes, Give                             |                    | _   | Specify:      | david villodinį diesi)                        | Canaihu                              |                                    |
| ğ                 | hours after death with the Maryland<br>turet; or items 23e or 28e-f show<br>at Evaritier must be notified at  | d by           | 3 Widowed 4 Divorced   | Year or Dates:  |                    |   | tion          |   | 16b. Kind of Business/               | nite                               |
| 21215-0036        | in 72   | Completed      | 15. Decedent's Educ<br>(Specify only highest grade   | completed)  | (Give              | lent's Usual Occupa<br>kind of work done d<br>DO NOT use retired) | luring most o | f working                                     | TOD. KING OF BUSINESS                | industry                           |
| 212               | filed within 72<br>Hygiene.<br>other then "nalesnt, I're Medic  | mo<br>d<br>m   | Elementary/Secondary (0-12)  | College (1-4or 5+) 5                                      |                    | roker & H   |               |   | At Hor                               | ne                                 |
|                   | a filed wil<br>Il Hygien<br>other th  | BeC            | 17. Father's Name (First, Middle, Last)  |   |                    |   | 18. Mother's  | Name (First, Middle, I                        | Maiden Sumame)                       |                                    |
| <u> a</u>         | should be<br>nd Mental<br>i marked c  | To E           | George E. Tzomic   | les   |                    |   | P             | lgnes P.                                      | Padousis                             |                                    |
| Maryland          | 2 sho<br>and I<br>is me   |                | 19a. Informant's Name/Relationship (Typ  |   |                    |   |               | or Rural Route Number                         |                                      |                                    |
|                   | s 1 and 2 should be filed within 72 hours after death with the Marylan if Health and Mental Hygiene. If the file and Mental Hygiene item 27 is marked other then "naturel", or items 23e or 28e-1 show other treumetic event, I.e. Medical Evaninar must be notified at |                | Mr. William J. Pate  |   |                    | 5 Greensp.<br>sition (Name of                                     | ring V        |   | Stevenson<br>20c. Location - City or |                                    |
| <u> </u>          | Pages nent of hent of hent: if ite  |                | 20a. Method of Disposition 1 ⊠Burial 2 □ Cremation 3 □ Re  | emoval from State   | netery, crer       | natory or other place   | 1             |   | •                                    |                                    |
| altimore,         | permit. Pages Department of Importent: if it any injury or once.  |                | *4 □Donation 5 □ Other (Specify)  21. Signature of Funeral Sarvice Inc. nse  | 1 1 1-1   |                    | nodox Cem   |               | 12/21/05                                      | Baltimore                            | Maryland<br>21204                  |
| Ba                | Depi<br>impo<br>any   |                | 1 Michoux  | Book Xin  |                    |   | ,             | Home, Inc. 10                                 | 050 York Road                        |                                    |
|                   | 5   |                | 23a. Part1. Enter the disease, or complice shock, or heart failure. List only one  | cations that caused the death.                            |                    |   |               |   |                                      | Approximate<br>Interval Between    |
|                   | Pnysician :   |                | Immediate Cause (Final disease or condition  | Rectal Con  |                    |   |               |   |                                      | Onset and Death                    |
|                   | /Medical  |                | resulting in death)  | Due to (or as a conseque                                  | nce of):           |   |               |   |                                      | 1 4 MON W.2                        |
|                   | Examiner  |                | Sequentially list conditions, b.   |   |                    |   |               |   |                                      |                                    |
| : /               | be tis  | Examiner       | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of injury  | Due to (or as a conseque                                  | nce of):           |   |               |   |                                      |                                    |
| 14                | be executed<br>sician and<br>burial-transit   | хап            | that initiated events c. resulting in death) Last  | Due to (or as a conseque                                  | nce of):           |   |               |   |                                      |                                    |
| 760,              | te be executed<br>ysician and<br>le burial-transit  | icalE          |  |   |                    |   |               |   |                                      |                                    |
| 9                 | g physias the   | edic           | 0.   |   |                    |   |               |   |                                      |                                    |
| ŏ                 | leath certific<br>attending p   | an/N           | 23b. Was decedent pregnant   | 3c. If yes, outcome of pregnand 1 Live birth 2 Fetal d    |                    | Ectopic pregnancy   |               |   | 23d. Date of del                     | ,                                  |
| B                 | e deal  | Physician/Med  | in the past 12 months? 1 Yes 2 No  | 4☐Pregnant at time of dea 9☐Unknown                       |                    | Other (specify)   |               |   | Month                                | Day Year                           |
| P.0               | The law requires that the death certifical ate has been signed by the attending phyage 2 should be detached for use as the  | Phy            | 9 ☐ Unknown  Part II. Other significant conditions conf  | tributing to death but not result                         | ing in the u       | nderhijng cause gwe   | n in Part I   | 23e Did tol                                   | pacco use contribute to              | the cause of death?                |
| Records,          | signe<br>d be c   | d by           | Turring of the state of the sta | and the down but not room.                                | ing in the di      | naony ng baabo giva   |               | 1 □ Ye  |                                      | obably 4 Unknown                   |
| Š                 | w requir<br>been si<br>should   | etec           |  |   |                    |   |               | 24a. Was a                                    | n 24h Were au                        | topsy findings available           |
| Re                | The lav   | Completed      |  |   |                    |   |               | autops<br>perforr                             | ned? prior to death?                 | completion of cause of             |
| ta                | ician: Th<br>certificate<br>rector, pag   | Be Co          | 25. Was case referred to medical   |   |                    |   | 26. Place of  | 1 ☐ Yes 2<br>1 Death (Check only on           | 2 <b>∑</b> No 1 ☐ Yes                | 2 No                               |
| 2                 | ysician:<br>is certific<br>director,  | To B           | examiner? 1 Tyes 2 No  | ospital:<br>1 ☐ Inpatient 2 ☐ El                          | R/Outpatier        | t 3 DOA Othe  |               | ing Home 5 Reside                             |                                      | city)                              |
| 0 0               | Attending Physician: r death. ector: After this certifics by the funeral director, p  |                | 27. Manner of Death Natural 5 □ Pending  | 28a. Date of Injury 2<br>(Month, Day Year)                | 8b. Time of Injury | 28c. Injury<br>Work   | at            | 28d. Describe ho                              | ow injury occurred                   |                                    |
| Sio               | tendi<br>eath.<br>for: A<br>the fu  | cati           | 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be  |   |                    |   | /es 2 □ No    |   |                                      | 12 - 1 1 - 1                       |
| Division of Vital | i or At<br>after d<br>Direct<br>J in by   | Certification; | 4 Homicide determined  | 28e. Place of Injury - At hom<br>building, etc. (Specify) | e, farm, str       | eet, factory, office  |               | City or Town                                  | reet and Number or Ru<br>n, State)   | rai Houte Number,                  |
| _                 | spitei<br>ours a<br>nerel l   |                | 29a. Certifier Certifying Phys   | ician: To the best of my knowl                            | edge, deat         | n occurred at the tim   | e. date and i | place, and due to the ca                      | ause(s) and manner as                | stated.                            |
|                   | To the Hospitei or Attending Phys within 24 hours after death.  To the Funerel Director: After this completely filled in by the funeral di  | Medical        | (Check only 2 Medical Examin   | er: On the basis of examinatio<br>and manner stated.      | n and/or in        | vestigation, in my op   | inion, death  | occurred at the time, d                       | ate and place, and due               | to the cause(s)                    |
|                   | To th<br>withir<br>To th<br>comp  | Me             | 29b. Signature and title of certifier  | DIRECTOR,   |                    | 29c. License  |               |   | 9d. Date signed (Monti               |                                    |
| •                 |   |                | Eass Comhann   | MEDICIAL ONCOL  | Doy                | 02  | 3675          |   | 12-20.                               | つつ                                 |
|                   | 15  |                | 30. Name and address of person who cor   | mpleted cause of death (Item 2                            | 23а) (Туре,        | Print) (a.d   | 4.4           | R. H.   | 12-20.<br>one, NO 2                  | 1721                               |
|                   | 12  |                | Ross C. Donehouer, MD.  31. Date filed (Month, Day, Year)  | Johns Hofu<br>32. Registrar's Signatu                     | INS U              | men min   | <del>~</del>  | LO WIN  | and into                             | 21231                              |
|                   | Sta<br>Regista  |                | DEC 2 3 2005   | Landon St.  | 1000               | El s  |               |   |                                      |                                    |

| '                          |   |                | 1 - For<br>Stete<br>Registrar  | State of M                                   | Marylan            |                              |                                    |                            | ealth a<br>Death                      |                        |   | giene 0                   | 5                      | 41542   |
|----------------------------|---|----------------|--|--|--------------------|------------------------------|------------------------------------|----------------------------|---------------------------------------|------------------------|---|---------------------------|------------------------|---|
|                            |   |                | 1. Decedent's Name (First, Middle, Las   | t)   | -                  |                              |                                    |                            |                                       |                        | 2. Date of De                             |                           | V                      | 3. Time of Death                                |
|                            | Physici<br>/Medic   |                | Herbert Lee  | Pippin                                       |                    |                              |                                    |                            |                                       |                        | DECEMBI                                   |                           | 005                    | 9:00A. M  |
| >                          | Examin  |                | 4a. Facility Name (If not institution, give                                      | street and number                            | er)                |                              | 4b. City,                          | Town, or                   | Location of                           | of Death               |   | 4c. County                |                        |   |
|                            |   |                | 2612 EDGEWOOD AVE  |  |                    |                              |                                    | RKVIL                      |                                       | 0411-                  |   | BALTI                     |                        |   |
|                            | Funeral   |                | 5. Social Security Number 6. Social Security Number 1                            | 9X 7.7<br>▼ M 2 F                            | Age (In yrs.<br>78 | last birthday)<br>Yrs.       | Months                             | Days                       | If Under<br>Hours                     | Min.                   | 8. Date of Birt<br>(Month, Da<br>Aug . Zl | , 1927                    | Cou                    | place (State or Foreign<br>ntry)<br>INESSEE     |
|                            | Director  |                | Usual Residence of Decedent  |  |                    |                              |                                    |                            |                                       |                        | nuy. 2                                    | 3, 1227                   | 161                    | 11100000  |
|                            | yland<br>yland  |                | 10a. State 10b. County   |  | 10c. Cit           | y, Town or Lo                | cation                             |                            |                                       |                        |   |                           |                        | 10d. Inside City Limits                         |
|                            | a-f st  | ctor           | Md. Baltimo:   | re   | Pa                 | rkvill                       | е                                  |                            |                                       |                        |   |                           |                        | 1 ☐ Yes 2X No                                   |
|                            | or 28   | Director       | 10e. Street and Number   |  |                    |                              | 10f. Zip                           | Code                       |                                       |                        |   | 10g. Citizen of V         | hat Cou                | ntry?   |
|                            | ath w   | rai            | 2612 Edgewood A  |  |                    |                              |                                    | 21                         | 234                                   |                        |   |                           | L                      | ISA   |
|                            | er de   | Funerai        | 11. Marital Status   | 12. Was Deceder<br>Armed Force               | s?                 | .S. 13. 1                    | Was Dece<br>f Yes, spe             | dent of His<br>cify Cubar  | spanic Ori<br>n, Mexican              | gin? (Spe<br>n, Puerto | ecify Yes or No-<br>Rican, etc.)          |                           | e - Ameri<br>k, White, | can Indian,<br>etc.                             |
| 36                         | rs aft  | by F           | 1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced                           | 1 ☑ Yes 2 [<br>If Yes, Give<br>Year or Dates | <.<br>□ No         |                              | 1 🗆 Yes                            | 2 <b>X</b> No              | Specify:                              |                        |   | Specify                   | · u                    | ite   |
| 8                          | within 72 hours after deeth with the Maryland<br>ene.<br>than "natural", or items 23a or 28a-f show<br>tha Mudical Examinar must be notilied at   | ed             | 15. Decedent's Ed  |  |                    | 16a. Dece                    | dent's Usu                         | al Occupa                  | ition                                 |                        |   | 16b. Kind of Bu           |                        |   |
| 215                        | hin 7   | Completed      | (Specify only highest gra  | de completed) College (1-4o                  | or 5+)             | (Give                        | kind of wo<br>DO NOT u             | ork done d<br>ise retired, | luring mosi<br>)                      | t of worki             | ng  |                           |                        | ŕ   |
| 21                         | e filed within al Hygiene. I other than "   | E O            | 8  |  |                    | Truc                         | k Dri                              | iver                       |                                       |                        |   | Trucki                    | ng                     |   |
| B                          | al Hy<br>d oth  | Be (           | 17. Father's Name (First, Middle, Last)  |  |                    |                              |                                    |                            |                                       |                        |   | Maiden Sumam              | e)                     |   |
| yla                        | 2 should be to and Mental to the marked of raumatic even  | ၉              | Edward Pippin  |  |                    |                              |                                    |                            |                                       | ary                    | Canada                                    |                           |                        |   |
| Maryland 21215-0036        | s 1 and 2 should be filed within 72 hours after deeth with the Marylan if Health and Mental Hygiene if the filem 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event. Ite Mardical Examinar must be notified at |                | 19a. Informant's Name/Relationship (7  |  |                    |                              |                                    |                            |                                       |                        |   | er, City or Town,         |                        | o Code)   |
| മ്                         | s 1 and 2<br>if Health<br>item 27 l   |                | Mrs. Mary F. Pipp:   | ru/ mile                                     | 20b. F             | ∠   ∪∠<br>Place of Dispo     |                                    |                            | AVE.                                  |                        | ate                                       | , Md. 21                  |                        | own State                                       |
| õ                          | nt of<br>nt of<br>t: If it  | 1              | 1 ☐ Burial 2 ☐ Cremation 3 ☐   |  | te                 | emetery, crer<br>.1top S     | natory or o                        | other place                | ´ 1 .                                 | 12-21                  |   | Towson,                   |                        |   |
| altimore,                  | permit. Pages Department of t important: If its any injury or of  | 1              | 4 ☐ Donation 5 ☐ Other (Specify<br>21. Signature of Fuperal Service Licen        |  | 11177              | ,                            |                                    |                            |                                       |                        | _   |                           | riu.                   |   |
| Ba                         | Depa<br>impo<br>any i   |                | · CALT   | 3/1  |                    |                              | Ruc                                | ck To                      | wson                                  | Fune                   | eral Hor                                  | ne, Inc.<br>Md. 2120      | 1.                     |   |
|                            |   |                | 23a. Part1. Enter the disease, or composition shock, or heart failure. List only | lications that caus                          | ed the deat        | h. Do not ent                | er the mod                         | de of dying                | , such as                             | cardiac c              | r respiratory ar                          | rest,                     | 1                      | Approximate<br>Interval Between                 |
|                            | Physician   |                | Immediate Cause (Final disease or condition                                      | (1) I/L-                                     | tart               | Shota                        | 1110                               | Wou                        | end                                   | to                     | Head                                      |                           |                        | Onset and Death                                 |
| ?                          | /Medical  |                | resulting in death)  |  | as a conseq        |                              | uri                                |                            | - •                                   |                        |   |                           |                        |   |
|                            | Examiner  |                | Sequentially list conditions   | b  |                    |                              |                                    |                            |                                       |                        |   |                           |                        |   |
| 47                         | sit ad  | ine            | if any, leading to immediate cause. Enter Underlying Cause (Disease or injury    | Due to (or a                                 | as a conseq        | uence of):                   |                                    |                            |                                       |                        |   |                           |                        |   |
| 43                         | and<br>and<br>I-tran  | Examiner       | that initiated events resulting in death) Last                                   | cDue to (or a                                | as a conseq        | neuce ot).                   |                                    |                            |                                       |                        |   |                           | _                      |   |
| 8760,                      | death certificate be executed<br>e ettending physician and<br>id for use as the burial-transit  | dicai E        |  |  | ,                  |                              |                                    |                            |                                       |                        |   |                           |                        |   |
| 687                        | ficate<br>g physics<br>ts the   | edic           |  | a  |                    |                              |                                    |                            |                                       |                        |   |                           |                        |   |
| Вох                        | eath certifi<br>ettending  <br>for use as   | N/             | IF FEMALE:<br>23b. Was decedent pregnant   | 23c. If yes, outcom                          |                    |                              |                                    |                            |                                       |                        |   | 23d. Date                 | of deliv               | ery   |
| œ.                         |   | icia           | in the past 12 months?<br>1 ☐ Yes 2 ☐ No   | 1 ☐ Live birth<br>4 ☐ Pregnant               | at time of d       |                              | Ectopic p<br>Other (s <sub>t</sub> |                            |                                       |                        |   | Mor                       | nth                    | Day Year  |
| P.O.                       | that the deatl<br>ed by the ette<br>detached for  | Physician/Me   | 9 Unknown  | 9□ Unknown                                   |                    |                              |                                    |                            |                                       |                        |   |                           |                        |   |
|                            | S 5 0   | by             | Part II. Other significant conditions of   | intributing to death                         | but not res        | ulting in the u              | nderlying                          | ause give                  | n in Part I.                          |                        |   | V/                        |                        | he cause of death?                              |
| ord                        | w require<br>been sig<br>should b   | ted            |  |  |                    |                              |                                    |                            | · · · · · · · · · · · · · · · · · · · |                        | 1 D Y                                     | es 2 No                   | 3 🗍 Prot               | oably 4 ∐Unknown                                |
| ec                         | has b   | Completed      |  |  |                    |                              |                                    |                            |                                       |                        | 24a. Was<br>autop                         | sy p                      | rior to co             | psy findings available<br>impletion of cause of |
| Division of Vital Records, |   |                |  |  |                    |                              |                                    |                            |                                       |                        | perfor<br>1 X Yes                         | med? d<br>2 □ No 1        | ath?<br>Yes            | 2 🗆 No  |
| <b>#</b>                   | Attending Physician: r death. ector: Atter this certific by the funeral director.   | Be             | 25. Was case referred to medical examiner?                                       | Hospital:                                    |                    |                              |                                    | Othe                       | _                                     |                        | (Check only o                             |                           | -                      |   |
| οţ                         | Phys<br>r this<br>ral di  | ): To          | 1X Yes 2 No 27. Manner of Death  | 28a. Date of tr                              | njury              | ER/Outpatien<br>28b. Time of |                                    | 28c. Injury                | 4 🗀 190                               |                        |   | lence 6 XOthe             |                        | SCENE .   |
| on                         | th.<br>: Afte   | tior           | 1 □Natural 5 □ Pending 2 □ Accident investigation                                | (Month, E                                    | Day Year)          | Fruid<br>8:40                |                                    | Work                       | es 2 N                                |                        | Sub                                       |                           | 4                      | Self  |
| <u>N</u>                   | Atter<br>r dea<br>ector<br>by the   | ifica          | 3 Suicide 6 □ Could not be<br>4 □ Homicide determined                            | 286. Place of I                              | Injury - At ho     | ome, farm, str               |                                    | y, office                  |                                       |                        | 28f. Location (S                          | )<br>treet and Numbe      | er or Rura             | al Route Number,                                |
| Ó                          | s afte<br>ni Dire<br>ed in b  | Certification: | 4 - Horricide  | building,                                    | etc. (Specif       | of r                         | eside                              | ince                       |                                       |                        | City or Ton                               | m. State) 260<br>Luille M | 2 Fa                   | gewood Ave                                      |
|                            | To the Hospital or Attending Phywithin 24 hours atter death. To the Funeral Director: After thi completely filled in by the funeral   |                | 29a. Certifier 1 Certifying Ph   | ysicien: To the be:                          | st of my kno       | wledge, death                | occurred                           | at the tim                 | e, date and                           | d place, a             | and due to the d                          | cause(s) and mar          | nner as s              | tated.  |
|                            | To the H<br>within 24<br>To the F<br>complete   | Medical        | one) A   | and manner                                   | stated.            | ori and/or in                |                                    |                            |                                       | occur                  |   |                           |                        |   |
|                            | T with  | -              | 29b. Signature and title of certifier  | .0   | 1                  |                              | 290                                | c. License                 |                                       |                        |   | 29d. Date signed          |                        |   |
|                            |   |                | Colorina   | elann  |                    |                              |                                    | 0.C.                       | M.E.                                  |                        |   | ECEMBER                   | 20,                    | 2005  |
| 1.                         | 5+1   |                | 30. Name and address of person who   |  | f death (Iten      | п 23а) (Туре,                |                                    | PENN                       | STRE                                  | ET F                   | AT TTMOE                                  | RE, MARYL                 |                        | 21 201  |
|                            | Sta   | te             | 31. Date filed (Month, Day, Year) DEC 2 3 201                                    | 32. Regis                                    | strar's Signa      | ture                         | Ales .                             |                            | ~ 1111                                | L                      |   | طلعاد <u>د</u> د و سد     |                        |   |
|                            | Registr   | ar             | DEC 2 3 201  | 15 MA  | and S              | · Marie                      | 1                                  |                            |                                       |                        |   |                           |                        |   |

## Plea

| ase | Type or Print in Black Indelible Ink | <ol> <li>Ensure All Copies Are L</li> </ol> | egibl |
|-----|--------------------------------------|---|-------|
|     | State of Maryland / Department of I  | Health and Mental Hygiege                   |       |

|         | ,  |                  | 1 - State of Maryland / Depi  | artment of Health and I<br>rtificate of Death   |  | giene 005                      | 41543  |
|---------|--|------------------|---|---|--|--------------------------------|--|
|         | Physici  | an               | Decedent's Name (First, Middle, Last)     Leslie Benjamin Perez   | -   | 2. Date of Dea                         | ath<br>Day Year                | 3. Time of Death                                   |
|         | /Medic   | cal              | 4a. Facility Name (Kaptinstitution give street and number)  4a. NORTH POINT # 56  | 4b. City, Town, or Location of Deatl  | DEC.                                   | 20, 2005<br>4c. County of Deat |  |
|         |  |                  |   | DUNDALK  If Under 1 Year   If Under 24 Hrs.   | 12=                                    | BALTIMO                        |  |
|         | Funeral<br>Director  |                  | 5. Social Security Number  6. Sex 1 M 2 F  7. Age (In yrs. last birthday) 60 Yrs.  Usual Residence of Decedent  | If Under 1 Year   If Under 24 Hrs.   Months   Days   Hours   Min.                                 | 8. Date of Birt<br>(Month, Da<br>MAY 6 | 1945 Eng                       | hplace (State or Foreign<br>untry)<br>Land         |
|         | yland<br>how   |                  | 10a. State 10b. County 10c. City, Town or Lo  |   |  |                                | 10d. Inside City Limits                            |
|         | he Ma  | ector            | MD Baltimore Dundalk  |   |  |                                | 1 ☐ Yes 2X No                                      |
|         | ath with t   | Funeral Director | 3701 North Point Road, #56  | 10f. Zip Code<br>21222  |  | 10g. Citizen of What Co<br>US  | untry?   |
| 200     | be filed within 72 hours after death with the Maryland ital Hyglene. d other than "natural", or itams 23a or 28a-1 show event, its Modical Examinat must be notified at                | þ                | 1 Never Married 2 Married 1 Married 2 No  | Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert 1 ☐ Yes 2 🖾 No Specify: | pecify Yes or No<br>o Rican, etc.)     | Canaitu                        |  |
| ה<br>ה  | n 72 h   | jete             | (Specify only highest grade completed) (Give  | dent's Usual Occupation<br>a kind of work done during most of wor<br>DO NOT use retired)          | king                                   | 16b. Kind of Business/         | Industry   |
| 7 1 7   | d withi<br>giene.<br>er then   | Completed        | Elementary/Secondary (0-12)   College (1-4or 5+)  | Tech. Supervisor  |  | City of B                      | altimore   |
| 2       | d be file<br>antal Hy<br>sed oth<br>c event  | Be               | 17. Father's Name (First, Middle, Last)  Joseph Perez   | 18. Mother's Nar<br>Olive   | ne (First, Middle,<br>Mae              | Maiden Sumame) Black Mo:       | re   |
| al      | 2 should<br>and Me<br>Is mark<br>aumati  | 은                | 19a. Informant's Name/Relationship (Type, Print) 19b. Maili   | ing Address (Street and Number or Ru  | ral Route Numbe                        | or, City or Town, State, 2     | Zip Code)  |
| ≥<br>2  | Health<br>tsm 27<br>other tr   |                  | 9   | East 31st Street osition (Name of matory or other place)  | , Dalli                                | 20c. Location - City or        | 1218<br>Town, State                                |
| Dalimon | permit. Peges 1 and 2 should be filed within Depertment of Health and Mental Hygiene. Important: It itsm 27 is marked other than 1 any Injury or other traumatic event, II is Manance. |                  | 4 Donation 5 Other (Specify) Chesapeake   | Crematory Inc 12/2  |  | Beltsville                     |  |
| 0       | permit<br>Deper<br>Impor<br>any In   |                  | 21. Signature of Funeral Service, Licensee M00986   | Ara, astephehaib. I<br>717 Green Pasture  | ohrmann,<br>s Drive,                   | PA<br>Towson, M                | 21286  |
|         |  |                  | 23a. Part1. Enter the disease, or complications that caused the death. Do not en<br>shock, or heart failure. List only one cause on each line. Immediate Cause (Final | ter the mode of dying, such as cardiac  | or respiratory ar                      | rest,                          | Approximate<br>Interval Between<br>Onset and Death |
|         | Physician<br>/Medical<br>Examiner  |                  | disease or condition resulting in death)  a.  |   |  |                                |  |

|                                |  |                       | Allend Itel#1, perm   | 'State of I  | Vlarylan                       |                                 | artment o<br>rtificate                            |                               |                                  | nd M       |  | giene<br>Reg. No.               | )5                                       | 4   5                   | 5 4 4                               |
|--------------------------------|--|-----------------------|---|--|--------------------------------|---------------------------------|---|-------------------------------|----------------------------------|------------|--|---------------------------------|--|-------------------------|-------------------------------------|
|                                | Physic   |                       | 1. Decedent's Name (First, Middle, Las  |  | danivia                        | a Cook V                        | DA De Po  | ortaro                        | •                                |            | 2. Date of De<br>Month<br>12           | ath<br>Dav                      | 005                                      |                         | ne of Death<br>8:40 pm              |
| 1                              | /Medi<br>Examii  |                       | 4a Facility Name (If not institution, give  |  |                                |                                 |   | 4b. 0                         | City, Tow                        | n, or Lo   | cation of Death                        |                                 | nty of Death                             |                         | 3.40pm                              |
| A.                             |  |                       | Brookgrove Rehabi   |  |                                |                                 |   | 1                             |                                  | -          | oring                                  |                                 | ontgor                                   |                         |                                     |
|                                | Funeral<br>Director  |                       | 5. Social Security Number 6. Se 229-51-6844   | x  | Age (In yrs.<br>95             | last birthday)<br>Yrs.          | If Under 1 \ Months D                             |                               | Under 2<br>Hours                 | Min.       | 8. Date of Bir<br>Month, Da<br>10-25   | 1910                            | 9. Birth<br>Cou<br>Pe1                   | place (Si<br>ntry)<br>U | tate or Foreign                     |
|                                | and w  |                       | Usual Residence of Decedent  10a. State 10b. County   |  | 10c. Cit                       | y, Town or Lo                   | cation  |                               |                                  |            |  |                                 |  | 10d Insid               | de City Limits                      |
|                                | Manyl<br>f sho   | ō                     | MD Montgo   | merv   |                                | Sandy                           |   |                               |                                  |            |  |                                 |  |                         | ∛res 2 □ No                         |
|                                | or 28a   | rec                   | 10e. Street and Number  |  |                                |                                 | 10f. Zip Co                                       | ode                           |                                  |            |  | 10g. Citizen                    | of What Cou                              | ntry?                   |                                     |
|                                | 23a c  | a                     | 18131 Slade Schoo   | 1 Rd.  |                                |                                 |   | 20                            | 0880                             |            |  | USA                             |  |                         |                                     |
| 020                            | s 1 end 2 should be filed within 72 hours efter death with the Marylend<br>Health and Mental Hygiene.<br>Item 27 is marked other than "natural", or items 23e or 28e-f show<br>other traumatic event, the Medical Examiner must be notified at | by Funeral Director   | 11. Marital Status  1 □ Never Married 2 □ Married  3 □ Oswidowed 4 □ Divorced   | 12. Was Decede<br>Armed Force<br>1 Yes 25<br>If Yes, Give<br>Year or Date: | s?<br>] No                     |                                 | Was Deceden<br>f Yes, specify                     |                               | nic Orig<br>Mexican,<br>Specify: | _          | ecify Yes or No<br>Rican, etc.)<br>ino | - 14. F<br>B<br>Spec            | tace - Ameri<br>lack, White,<br>cify: Wh |                         | .n,                                 |
| 5-0                            | 72 ho<br>natur   | ed                    | 15. Decedent's Edu<br>(Specify only highest grad  | cation<br>e completed)   |                                | 16a. Deced                      | lent's Usual O<br>kind of work of<br>DO NOT use r | Occupation                    | n<br>na most :                   | of workii  | na                                     | 16b. Kind of                    | Business/In                              | dustry                  |                                     |
| 121                            | vithin<br>ne.<br>han "   | ğ                     | Elementary/Secondary (0-12)   | College (1-4c  | or 5+)                         |                                 |   | retired)                      | .goo.                            | Or WO71117 | <i>.</i> 9                             | •                               |  |                         |                                     |
| d 2                            | filed v<br>Hygie<br>ther t   | Be Completed          | 17. Father's Name (First, Middle, Last)   |  |                                | HOM                             | emaker  | 18                            | . Mother                         | 's Name    | (First, Middle,                        |                                 | n Home                                   |                         |                                     |
| lan                            | lid be<br>fental<br>ked o  | To Be                 | Herminio Urdaniv  | ia   |                                |                                 |   |                               |                                  |            | a Cook                                 |                                 | ,  |                         |                                     |
| Baltimore, Maryland 21215-0020 | nd 2 should be filled within lith and Mental Hygiene. 27 is marked other than r traumatic evant, the Mi  |                       | 19a. Informant's Name/Relationship (T)<br>Nina Burke/daught   |  |                                |                                 |   |                               |                                  |            | Houte Numberies                        |                                 |  | c Code)                 |                                     |
| re,                            | es 1 end 2<br>of Health<br>of Health<br>I item 27 h  |                       | 20a. Method of Disposition  |  |                                | lace of Disposemetery, cren     | sition (Name                                      | of<br>r place)                |                                  | 1          | Date                                   | 20c. Locatio                    | n - City or To                           | own, Stat               | te                                  |
| i                              | Page<br>nent c   |                       | 1 ☐ Burial 2 🛣 Cremation 3 ☐ F<br>4 ☐ Donation 5 ☐ Other (Specify)  |  | te                             | hesapea                         | -   |                               | ory                              | 1          | 2/23/0                                 | 5 Bel                           | ltsvi1                                   | 1e M                    | Œ                                   |
| Balt                           | permit. Pages<br>Depertment of<br>Important: If it<br>any Injury or once.  |                       | 21. Signature of Funeral Service Licens   | 7 -  | 135ء                           |                                 |   | Fune                          | era1                             | & C        | rematio                                |                                 |  |                         |                                     |
|                                |  |                       | 23a. Part1. Enter the disease, or compleshock, or heart failure. List only o  |  | • -                            | 1                               | er the mode of                                    | f dying, s                    | uch as c                         | ardiac o   | r respiratory a                        | rest,                           | 20910                                    |                         | imate<br>I Between                  |
| 1                              | Physician<br>/Medical  |                       | Immediate Cause (Final disease or condition   |  | 2A710                          |                                 | NEWM  |                               |                                  |            |  |                                 | 1  | Onset a                 | and Death                           |
|                                | Examiner   | -                     | resulting in death)   | 1.   | Due to (o                      | r as a conseq                   | uence of):  |                               |                                  |            |  |                                 | 1  |                         |                                     |
| et .                           | uted<br>J<br>insit   | E E                   |   | DYSPH  |                                |                                 |   |                               |                                  |            |  |                                 | İ  |                         |                                     |
| ,                              | cete be executed<br>physician end<br>s the buriel-transit  | dical Examiner        | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events | ADVA   |                                | as a conseq                     |   | 7                             | -40 1-4                          | 1 1        | Α.                                     |                                 | 1  |                         |                                     |
| 68760,                         | cete be<br>physicia<br>the bu  | cal                   | Cause (Disease or injury that initiated events resulting in death) Last   | - MEVIN  |                                | as a consequ                    | uence of):  | 125                           | MET                              | 011        | · 4.                                   |                                 |  |                         |                                     |
| _                              | entifice<br>ingph<br>east  |                       | Tooding in doding East  | 1  |                                |                                 |   |                               |                                  |            |  |                                 | 1  |                         |                                     |
| Вох                            | eath certifii<br>attending p<br>I for use as   | lan                   |   |  |                                |                                 |   |                               |                                  |            |  |                                 |  |                         |                                     |
| P.O.                           | t the de<br>by the a<br>stached t  | Physiclan/M           | Part II. Other significant conditions con   | tributing to death   | but not resu                   | ilting in the un                | nderlying caus                                    | e given ir                    | Part I.                          |            |  | obacco use o                    |  |                         |                                     |
|                                | es that<br>igned b   | by Pt                 | -   |  |                                |                                 |   |                               |                                  |            | 10                                     | ∕es 2⊡No                        | 3 ∐ Pro                                  | bably                   | 4∰Unknown                           |
| Records,                       | aw requir<br>is been s<br>2 should   | Completed t           |   |  |                                |                                 |   |                               |                                  |            | 24a. Was<br>perfo                      | an autopsy<br>med?              | av                                       | ailable pi              | osy findings<br>rior to<br>of cause |
|                                | The ate h  | Con                   |   |  |                                |                                 |   |                               |                                  |            | 1 D Y                                  | es 2⊠No                         | 10                                       | Yes                     | 2□No                                |
| Vita                           | Physician: The<br>this certificate<br>ral director, pec  | Be                    | 25. Was case referred to medical examiner?  | lospital:  |                                |                                 |   |                               | . Place c                        | of Death   | (Check only o                          | ne)                             |  |                         |                                     |
| of Vital                       | Phys<br>this<br>raidi  | J.                    | 1 ☐ Yes 2 ☐ No  | 1 🗆 Inpa   |                                | ER/Outpatient<br>28b. Time of   |   |                               | 4 🗷 Nurs                         | -          | ne 5 Resid                             |                                 |  | y)                      |                                     |
| on                             | Attending I<br>r death.<br>actor: After<br>by the funer  | tiol                  | 1 Natural 5 ☐ Pending<br>2 ☐ Accident investigation   | 28a. Date of In<br>(Month, L   | ay Year)                       | Injury                          |   | Injury at<br>Work?<br>1 ☐ Yes | 2 🗆 No                           |            |  | on injury occ                   | unou                                     |                         |                                     |
| Division                       | I or Attendi<br>efter death<br>Diractor: A<br>d in by the f  | ertifica              | 3 Suicide 6 Could not be determined   | 28e. Place of I<br>building,   | njury - At ho<br>etc. (Specify | me, farm, stre                  | eet, factory, of                                  | fice                          |                                  | 2          | 8f. Location (S<br>City or Tow         |                                 | nber or Rura                             | I Route I               | Vumber,                             |
|                                | To the Hospital or Attending I within 24 hours efter death.  To the Funerel Director: After completely filled in by the fune   | edical Certification: | 29a. Certifier 1 Certifying Physical (Check only one) 2 Medical Exami   | iclan: To the bes<br>ner: On the basis<br>and manner:                      | of examinati                   | vledge, death<br>ion end/or inv | occurred at the                                   | ne time, d<br>my opinio       | ate and<br>n, death              | place, a   | nd due to the o                        | ause(s) and r<br>late and place | nanner as s<br>e, and due to             | tated.                  | se(s)                               |
|                                | within<br>To the<br>compl  | Me                    | 29b. Signature and title of certifier   |  |                                |                                 | 29c. Lie  | cense nu                      | mber                             |            |  | 29d. Date sign                  | ned (Month,                              | Day, Yea                | ir)                                 |
|                                | /  |                       | 1900W   | e. mt  |                                |                                 | D   | 33                            | 700                              | )          | ũ                                      | Decemb                          | ser Z                                    | 2, -                    | 2005                                |
|                                | 5  |                       | 30. Name and address of person who co   |  | Α -                            | 23a) (Type, F                   |   | Τ.                            | WII                              | LIA        | mspo                                   | RT.                             | MD.                                      | -                       |                                     |
|                                | Sta<br>Registr   | 7.5                   | 31. Date filed (Month, Day, Year) DEC 2 3 20  | 32. Regis  | trer's Signat                  |                                 | act 3   |                               |                                  |            |  |                                 |  |                         |                                     |

Luther Rucker Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

I tems: 23a part 1,27,28a,b,c,d,e,f per MEO G-851 1/21/06 restricted by State of Maryland / Department of Health and Mental Hygiene. 05-08508 crn 1 - For State Registrat Certificate of Death Reg: No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** 16, 2005 4:00 P December /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner <u>514 N. Highland Avenue</u> Baltimore
If Under 1 Year | If Under 24 Hrs 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** Days Months Hours 1 M 2□ F 220-64-0412 Usual Residence of Decedent Yrs Director the Maryland 10a State 10b Counts 10c City Town or Location 10d. Inside City Limits 28e-f ehov or than "naturel", or itame 23a or 28e-f ehor 1 XYes 2 No Maryland
10e. Street and Number Directo more 10f. Zip Code 10g. Citizen of What Country? 10 Funeral Pages 1 and 2 should be filed within 72 hours after deeth 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Completed by Specify: Blau 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) al Hygiene. pente 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be is marked of Ve 2 19a. Informant's Name/Relationship (Type, Print) (Mother) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Heelth a important: If item 27 is any injury or other tran 1020 33rd 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 30/2005 armel 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Joseph L. Rus 12222 W. North 21. Signature of Funeral Service Licenses Funeral Home, PA Ave. Balto Md. 217 23a. Part / Enter the discase, or complications that cal-show, or heart fair re. List only one cause on each Approximate Interval Between Onset and Death the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final Hypothermia **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter of de lying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the deeth certificate be executed use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 ☐ Unknown After this certificete has been signed by funeral director, page 2 should be detected Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2X No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

YE Yes 2 □ No 24a. Was an autopsy performed? V peri 1□ Yes 2□No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner: 14 Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) at scene Certification: To 28a. Date of Injury at (Month, Day Year) 28b. Time of Find 28c. Injury at Injury 27. Manner of Death 28d. Describe how injury occurred Subject 1 Natural 2:47 P. M 5 Pending 12/16/05 Exposed to Cold Environment 1 ☐ Yes 2 XNo death. investigation naref Director: A 2 Accident 6 ☐ Could not be determined 3 Suicide 28e. Place of Injury: At home, farm, street, factory, office building, etc. (Specify) Vacant Building 28f. Location (Street and Number or Rural Route Number, City or Town, State) 514 N. Highland Ave hours after 4 Homicide Baltimore, Md. within 24 hours a To the Funarel L 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 The dical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) rull none O.C.M.E. December 17, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Margarita Korell, M.D. 111 Penn Street, Baltimore, Maryland 21201

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

ORIGINAL

32. Registrar's Signature

| 1 - State of Maryland / Department of Health and Mental Certificate of Death   | 7 2000 41040   |
|--|--|
| 1. Decedent's Name (First, Middle, Last)  2. Date  |  |
| Medical Ada Joyce Reese Dece   | mber 18 2005   08:15 p™  |
| Examiner  4a. Facility Name (If not institution, give street and number)  Keswick  4b. City, Town, or Location of Death  Baltimore   | 4c. County of Death N/A  |
| 5 Social Security Number 6 Sex 7 Age (in vrs. last birthday) If Under 1 Year   if Under 24 Hrs. 8 Date   | of Birth D Day Year)  9 Birthplace (State or Foreign Country)                          |
| Lisual Residence of Decedent   | 19 192/ Maryland   |
| 10a. State 10b. County 10c. City, Town or Location   | 10d. Inside City Limits  |
| Md. Howard Ellicott City  10e. Street and Number  10f. Zip Code  | 1 ☐ Yes 2 No   |
| 7943 Brightlight Place 21043   | USA  |
| 7943 Brightlight Place 21043  11. Marital Status 1 Never Married 2 Married 11. Never Married 2 Married 11. Never Married 2 Married 2 Married 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes Armed Forces?) 14. West Cap No.   | or No- 14. Race - American Indian,   |
| 1 Never Married 2 Married 1 Yes 2 No If Yes, Give 1 Yes, Give Vear or Dates:   | Specify: White   |
| 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working   | 16b. Kind of Business/Industry   |
| 1   Yes 2   No Specify:  1   Yes 2   No Specif | Own Home   |
| To a first Name (First, Middle, Last)  17. Father's Name (First, Middle, Last)  18. Mother's Name (First, Middle, Last)  |  |
| The state of the s |  |
| 19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route No. 19b. Mailing Address (Street and Number or Rural  |  |
| 20a. Method of Disposition  20b. Place of Disposition (Name of cemetery, crematory or other place)   | 20c. Location - City or Town, State  |
| Dulaney Valley Mem. 12-22-05   | Timonium, Md.  |
| 21. Signature of Fumeral Service Licenses  22. Name and Address of Facility Ruck Towson Funeral 1 1050 York Rd. Towson   | lome, Inc.   |
| 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respirat shock, or heart failure. List only one cause on each line.   | ory arrest, Approximate Interval Between   |
| Physician Immediate Cause (Final disease or condition resulting in death)  [Medical  | Onset and Death  4.  |
| Due to (or as a consequence of):   | U  |
| if any, leading to immediate Due to (or as a consequence of).  |  |
| P g g l = that initiated events  |  |
| Cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  |  |
|  |  |
| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes   2   2   2   2   2   2   2   2   2   | 23d. Date of delivery  Month Day Year  |
| 1 Yes 2 No 9 Unknown 9 Unknown  Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |
| ( )  | Did tobacco use contribute to the cause of death?    Yes 2   No 3   Probably   Unknown |
| The law require the law requirements of the law requir | Was an 24b. Were autopsy findings available  |
|  | prior to completion of cause of death? es 2 No 1 Yes 2 No                              |
| 25. Was case referred to medical examiner?  25. Was case referred to medical examiner?  1  | 1.   |
| To be the control of  | Residence 6 ROther (Specify) HOSPICE   |
|  | /2   |
| 2 Accident sinvestigation   M   1   Yes 2   No   | on (Street and Number or Rural Route Number,<br>r Town, State)                         |
| 286. Place of Injury - At home, farm, street, factory, office 28f. Local City of the strong of the street of the s | the cause(s) and manner as stated. Ime, date and place, and due to the cause(s)        |
| t till till till till till till till ti  | 29d. Date signed (Month, Day, Year)  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Kendale R Faul knemd/6565 N. Chaules St Suctor  State 31. Date filed (Month, Day, Year)  32. Registrar's Signature   | 12/20/2005   |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)   | 2 1  |
| Kendale R Faulkner MD/6565 N. Charles St Sucted  State Registrar  BEC 2 3 2005  State Registrar  | 03/BaltoMD   |

OPIGINA

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) Month **Physician** Elaine A. Reeder December 20, 2005 10:12 A M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Rockville Montgomery 15017 Westbury Road If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year)
Months | Days | Hours | Min. | (Month, Day, Year)
March | 15, 1933 5. Social Security Number 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) Funeral Months 1 □ M 2 1 F 72 Yrs. 213-30-2161 Maryland Director Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10a State 10b. County or 28a-f ehow Pages 1 and 2 should be filed within 72 hours after death with the Maryla nent of Health and Mantal Hygiene.

and: If them 27 Is marked other then "natural", or fleme 23a or 28a-f ehov and other traumatic event, "In Maufical Expire as must be notified at 1 ☐ Yes 2 X No Rockville Directo Maryland Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20853 United States 15017 Westbury Road Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc. 1 Never Married 2 Marned Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White 3 ☐ Widowed 4 A Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15 Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ann Elizabeth Wilczak Henry B. Kobylski 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 17820 Hidden Garden Lane, Ashton, Maryland 20861 David M. Reeder/Son 20b. Place of Disposition (Name of cemetery, crematory or other place)
Gardens of Faith 20c. Location - City or Town, State 20a. Method of Disposition Dec. 27, 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If eny Injury or once. Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 2005 Memorial Gardens 22 Name and Address of Facility
Robert A. Pumphrey Funeral Home/Rockville, Inc. 21. Signature of Funeral Service Licenses M00198 300 West Montgomery Ave., Rockville, MD 20850-2805 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Congestive Heart Failure Years Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Hypertension Years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner inding physicien and use as the burial-transit Years The law requires that the death certificate be executed Coronary Artery Disease Due to (or as a consequence of): resulting in death) Last P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ō in the past 12 months? 1 ☐ Yes 2 X No Month Day Year 4 Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by s been signe should be c 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ※ Unknown Diabetes Mellitus 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has l autopsy performed? 1 ☐ Yes 2 ☐ No this certificate 21 No 1 Yes the Hospital or Attending Physician: After this certification 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 | Inpatient Other: 4 ☐ Nursing Home 5 🖾 Residence 6 ☐ Other (Specify) Medical Certification: To 1 ☑ Yes 2 ☐ No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. 28d. Describe how injury occurred Injury at Work? 1 X Natural 5 Pending 1 TYes 2 Accident investigation 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide To use.
within 24 hours are
To the Funeral Dir 29a. Certifier 1 🖸 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 11743 December 21, 2005 35 30. Name and address of persop who completed cause of death (Item 23a) (Type, Print) 20307 6900 Georgia Avenue, N.W. Washington, D.C. S. Wilder, M.D. 32. Registrar's Signature 31. Date filed (Month, Day, Year) DEC 2 3 2005 Registrar

|                   |   |                 | 1 - For<br>State<br>Registrar  | State of Maryland /  |                            | rtment of H  |  | Reg  | ne<br>2005               | 41550  |
|-------------------|---|-----------------|--|--|----------------------------|--|--|--|--------------------------|--|
|                   | Physici<br>/Medio   | al              |  | ABAU   |                            | 4h City Tourn  | Location of Doub                                       | 2. Date of Death Month                         | Day The Rear             |  |
|                   | Examir  | er              | 4a. Facility Name (If not institution, given NORTHWEST HOSPIT)   |  |                            | RANDALL  | Location of Death                                      |  | 4c. County of Dea        |  |
| * A               | Funeral<br>Director   |                 | 5. Social Security Number 6. S   |  | Yrs.                       | If Under 1 Year<br>Months Days                               | If Under 24 Hrs.<br>Hours Min.                         | 8. Date of Birth<br>Month, Day, Ye<br>10/05/19 | 9. Bi                    | rthplace (State or Foreign ountry)           |
|                   | Maryland<br>n-f ehow  | tor             | 10a. State 10b. County   | 10c. City, To  |                            | ation<br>NGS MILL  | .S   |  |                          | 10d. Inside City Limits 1 ☐ Yes 2 ☐ No       |
|                   | vith the  | Director        | 10e. Street and Number   | -  |                            | 10f. Zip Code  | -  | 10g.   | . Citizen of What C      | •  |
|                   | ns 23a  | Funerai         | 12 WENGATE COUR  | 12. Was Decedent Ever in U.S.  | 13. W                      | 2111   |  | ecify Yes or No-                               | U.S.A.                   |  |
| 5-0036            | filed within 72 hours after death with the Maryland<br>Hygiene.<br>Ither then "naturel", or Items 23a or 28a-f ehow<br>with the Medical Exeminating the notiliard at  | d by Fun        | 1 Never Married 2 Married 3 Nation Widowed 4 Divorced  | Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:   |                            | Yes, specify Cuba<br>☐ Yes 2 🛣 No                            | ispanic Origin? (Sp<br>an, Mexican, Puerto<br>Specify: | Rican, etc.)                                   | Black, Wh                |  |
|                   | n 72 h  | letec           | 15. Decedent's Ed<br>(Specify only highest gra   | ducation 16<br>ide completed)  | (Give k                    | ent's Usual Occup<br>ind of work done of<br>ONOT use retired | during most of worl                                    | king 16t                                       | b. Kind of Busines       | s/Industry                                   |
| 2121              | be filed within tal Hygiene. Id other then event, its man   | Completed by    | Elementary/Secondary (0-12)  | College (1-4or 5+)   |                            | UNCH OPE   |  |  | TOOL SUF                 | PLIES  |
| nd                | 0 = 0 >   | Be              | 17. Father's Name (First, Middle, Last,  |  |                            |  |  | e (First, Middle, Mai                          | den Sumame)              |  |
| Maryland          | should be<br>ad Menta<br>marked<br>matic ev   | 은               | SELIG  19a. Informant's Name/Relationship (  | Type Print) 19   |                            | SS Address (Street   | MOLL I   | <b>L</b><br>ral Route Number, C                | ity or Town State        | ALPER<br>Zin Code                            |
|                   | and 2 salth ar  |                 |  |  |                            |  |  | INGS MILLS                                     |                          |  |
| altimore,         | permit. Pages 1 and 2 should be Department of Health and Menta Importent: If Item 27 is marked any injury or other traumatic app. 00041.  |                 | 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐  | Bemoval from State cemet   | tery, crem                 | ition (Name of atory or other place                          |  |  | c. Location - City o     |  |
| <u>=</u>          | it. Pa  |                 | 4 Donation 5 □ Other (Specification of Funeral S. No. Lines  |  | NEBO                       |  |  | 2/2005 GI<br>L LEVINSON                        | ENDALE,                  |  |
| e<br>B            | Dep<br>Imp  |                 | Jan March  | er.  |                            |  |  | ROAD - PI                                      |                          | 5117 (202)                                   |
|                   | Physician<br>/Medical   |                 | 23a. Part1 Enter he disease, or constock or hint failure. List only Immediate Cause (Final disease or condition resulting in death)                        | a. A OVANCED PUL  Due to (or as a consequence  | LMOIV<br>:e of):           | iny DI   | SG1SE .  |  |                          | Approximate Interval Between Onset and Death |
| ,8760,            | Attending Physicien: The law requires that the death certificate be executed redeath.  Setor: After this certificate has been signed by the attending physician and actor. After this certificate has been signed by the attending physician and actor the funeral director, page 2 should be detached for use as the burial-transit of | edicai Examiner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. CITZUNIC OBSTI  Due to (or as a consequence  Due to (or as a consequence  d.                    | e of):                     | LE LUNG  | 9 DISG-156   |  |                          | YK   |
| .O. Box 6         | that the death certific<br>ed by the attending p<br>detached for use as   | Physician/Me    | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes   2   No   9   Unknown  | 23c. If yes, outcome of pregnancy  1 Live birth 2 Fetal dea  4 Pregnant at time of death 9 Unknown |                            | Ectopic pregnancy<br>Other (specify)                         |  |  | 23d. Date of di<br>Month | elivery<br>Day Year                          |
| о.                | quires that<br>in signed by<br>uld be deta  | Ď               | Part II. Other significant conditions of   | contributing to death but not resulting  | g in the uni               | derlying cause giv   | en in Part I.  |  |                          | to the cause of death?  Probably 4 □Unknown  |
| I Records,        | The law requir<br>ate has been si<br>page 2 should i  | Completed       |  |  |                            |  |  | 24a. Was an autopsy performed                  | d? prior to death?       |  |
| Vita              | Physicien: The this certificate har director, page  | Be              | 25. Was case referred to medical examiner?   | Hospital:  |                            | Oth  |  | th (Check only one)                            |                          |  |
| Division of Vital | r Attending Phys<br>or death.<br>rector: After this is<br>by the funeral dis  | ation: To       | 1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending 2 Accident investigation   | 28a. Date of Injury<br>(Month, Day Year)   | Outpatient  Time of Injury | 28c. Injur<br>Wor  | 4 🗆 Nui sii ig rii                                     | ome 5 Residence 28d. Describe how              |                          | ecify)                                       |
| Divis             | safter death<br>safter death<br>al Director: A<br>ed in by the fi   | Certification:  | 3 Suicide 6 Could not be determined  |  | farm, stre                 | et, factory, office  |  | 28f. Location (Stree<br>City or Town, S        |                          | Rural Route Number.                          |
|                   | To the Hospital or Attentwithin 24 hours after deatl<br>To the Funaral Director:<br>completely filled in by the   | edicai          | one) 2 Medical Exam  | nysician: To the best of my knowled<br>miner: On the basis of examination<br>and manner stated.    | ga daath<br>and/or invi    | estigation, in my o  | pinion, death occur                                    | red at the time, date                          | and place, and du        | e to the cause(s)                            |
| ì                 | To You  | ×               |  | asky MD  |                            | 29c. Licens<br>D 5 4   | 4 LSS  | 29d.   | Date signed (Mor         | ith, Day, Year) 2003                         |
| 9                 | St  | ate             | 30. Name and address of person who IMO Will I  | completed cause of death (Item 23a<br>32. Registrar's Signature                                    | Me                         | ittive, t  | Hysper   | of Cart  | 7                        |  |

|                            |   |                  | 1 - For<br>State<br>Registrar   | State of Maryl                                    |                                    |                          | nt of He<br>te of D         |                               | Mental Hy                            | gien         | uua                          | 415           | 551               |
|----------------------------|---|------------------|---|---|------------------------------------|--------------------------|-----------------------------|-------------------------------|--------------------------------------|--------------|------------------------------|---------------|-------------------|
| ı                          | Physici   |                  | 1. Decedent's Name (First, Middle, La<br>Russel, Stone  | st)   |                                    |                          |                             |                               | 2. Date of De<br>Month               | eath<br>Da   | ay Year                      | . 2           | e of Death        |
|                            | /Medic<br>Examir  |                  | 4a. Facility Name (If not institution, giv  | e street and number)                              |                                    | 4b. City                 | , Town, or L                | ocation of Deat               | h                                    | 40           | c. County of Dea             |               |                   |
| T                          |   |                  | Franklin Squar  | e Hospita   |                                    | R                        | osed                        | lale                          |                                      |              | Bultin                       | lore          |                   |
| 2.                         | Funeral   |                  | 5. Social Security Number 6. S  | Sex 7. Age (In                                    | yrs. last birthday,                |                          | er 1 Year                   | If Under 24 Hrs<br>Hours Min. | 8. Date of Bir<br>(Month, Da         |              |                              |               | te or Foreign     |
| *                          | Director  |                  | 230-40-1413   | <b>X</b> M 2□ F                                   | 90 Yrs.                            | WOTTE                    | Days                        | 110013                        | January                              | 5,19         | 15 Wes                       | st Vir        | ginia             |
|                            | pu }  |                  | Usuel Residence of Decedent  10a. State 10b. County   | 100   | . City, Town or L                  | ocation                  |                             |                               |                                      |              |                              | 10d Incide    | e City Limits     |
|                            | shov  | 2                |   |   |                                    |                          |                             |                               |                                      |              |                              |               | es 2 XNo          |
|                            | Ne M  | ecto             | MD. Baltimo   | re  | Dundalk                            |                          |                             |                               | -                                    | 100          |                              |               |                   |
|                            | filed within 72 hours after death with the Maryland<br>Hygiene.<br>yther then "natural", or Items 23a or 28a-1 show<br>yet, the Medical Examiner must be positied at  | Funeral Director | 10e. Street and Number  | a   |                                    |                          | ip Code                     |                               |                                      | 10g. C       | itizen of What C             | ountry?       |                   |
|                            | s 23  | era              | 1884 Marshall Roa   | 12. Was Decedent Ever                             | 0116 12                            |                          | 21222                       | i- O-i-i-3 /0                 | `                                    |              | USA                          | sees ladios   |                   |
|                            | ler de  | Š                | 11. Marital Status  1 □ Never Married 2 □ Married   | Armed Forces?                                     | 11 0.5.                            | If Yes, sp               | ecify Cuban,                | , Mexican, Puer               | Specify Yes or No<br>to Rican, etc.) | o-           | 14. Race - Am-<br>Black, Whi |               | 1,                |
| 36                         | Irs af  | by F             | 3 Widowed 4 □ Divorced  | If Yes, Give<br>Year or Dates:                    |                                    | 1 🗆 Yes                  | 2 <b>X</b> No               | Specify:                      |                                      |              | Specify: TAT                 | hite          |                   |
| 21215-0036                 | 2 hou   | ed               | 15. Decedent's E  | ducation  | 16a. Dece                          | edent's Us               | ual Occupati                | ion                           |                                      | 16b. l       | Cind of Business             |               |                   |
| 15                         | n n   | plet             | (Specify only highest gra<br>Elementary/Secondary (0-12)  |   | (Give                              | b kind of w<br>DO NOT    | ork done du<br>use retired) | ring most of wo               | rking                                |              |                              |               |                   |
| 2                          | r the   | Completed        | 12 years  | College (1-4or 5+)                                | We                                 | lder                     |                             |                               |                                      | Bet          | hlehem :                     | Steel         |                   |
| ğ                          | othe<br>ont,  | BeC              | 17. Father's Name (First, Middle, Last,   | )   |                                    |                          | 1                           | 8. Mother's Na                | ne (First, Middle                    | , Maide      | n Surname)                   |               |                   |
| <u>a</u>                   | lenta<br>rked<br>rked   | To B             | Scott Stone   |   |                                    |                          |                             | Lela Ke                       | ller                                 |              |                              |               |                   |
| Maryland                   | permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Depertment of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-1 show may injury or other traumatic event, the Modical Examiner must be notified at ance.                                  | _                | 19a. Informant's Name/Relationship (  | Type, Print)                                      | 19b. Maili                         | ing Addres               | s (Street an                | id Number or Ri               | ırai Route Numb                      | er, City     | or Town, State,              | Zip Code)     |                   |
|                            | alth a  |                  | Bonnie Lou Leisur   | e Daughter  | 7241                               | Mart                     | cell A                      | venue,                        | Dundalk                              | MD.          | 21222                        |               |                   |
| Baltimore,                 | of Health ar<br>item 27 is<br>other trac  |                  | 20a. Method of Disposition  | 20  | b. Place of Dispo<br>cemetery, cre | osition (Na              | ame of other place)         | D                             | Date                                 | 20c. L       | ocation - City or            | Town, State   | •                 |
| Ë                          | Page<br>ent c<br>nt: 14   |                  | 1   Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specif   |   | cred Hear                          |                          |                             |                               | ember  <br>2005                      | Dur          | ndalk,MD                     | )             |                   |
| Ħ                          | mit.<br>Sorta<br>inju   |                  | 21. Signature of Funefal Service Lice   |   | -                                  |                          |                             |                               | ome Of I                             |              |                              |               |                   |
| m                          | Depermine any in poor   |                  | Chithony  | C. Con  | religy                             | onne.                    | oller                       | neral H<br>s Point            | Road, I                              | Juna<br>Juna | alk,P.A                      | 21222         | )                 |
|                            |   |                  | 23a. Part1. Enter the disease, or com   | plications that caused the                        |                                    |                          |                             |                               |                                      |              | alifia.                      | Approxi       | mate              |
|                            | Physician   |                  | shock, or heart failure. List only<br>tmmediate Cause (Final  | one cause on each line.                           |                                    |                          |                             |                               |                                      |              |                              | Onset a       | nd Death          |
| 1 30                       | /Medical  |                  | disease or condition resulting in death)  | a. Due to (or as a con                            | sequence of):                      |                          |                             |                               |                                      |              |                              |               |                   |
|                            | Examiner  |                  |   | 000 10 (01 03 0 001                               | 30000100 01).                      |                          |                             |                               |                                      |              |                              |               |                   |
|                            | 70.7  | 9                | Sequentially list conditions, if any, leading to immediate cause. End Underlying Cause (Disease or injury | b. Due to (or as a con                            | sequence of):                      |                          |                             |                               |                                      |              |                              |               |                   |
| V                          | d<br>ansit  | Examiner         | Cause (Disease or injury that initiated events  |   |                                    |                          |                             |                               |                                      |              |                              |               |                   |
| v<br>Č                     | n en  | Exa              | resulting in death) Last  | Due to (or as a con                               | sequence of):                      |                          |                             |                               |                                      |              |                              |               |                   |
| 8760,                      | rate be executed physician end the burial-transit   | cal              |   | d   |                                    |                          |                             |                               |                                      |              |                              |               |                   |
| 89                         | ifficat<br>g ph)<br>as th   | ed               | 1   |   |                                    |                          |                             |                               |                                      |              |                              |               |                   |
| Box 6                      | andin<br>use  | Physician/Med    | IF FEMALE;<br>23b. Was decedent pregnant  | 23c. If yes, outcome of pre                       |                                    | 75.                      |                             |                               |                                      |              | 23d. Date of de              | livery        |                   |
| 0                          | daati<br>e atte<br>d for  | Icla             | in the past 12 months?<br>1 ☐ Yes 2 ☐ No  | 1□Live birth 2□1<br>4□Pregnant at time            |                                    | □Ectopic p<br>□ Other (s |                             |                               |                                      |              | Month                        | Day           | Year              |
| P.O.                       | by the  | hys              | 9 Unknown   | 9□ Unknown  |                                    |                          |                             |                               |                                      |              |                              |               |                   |
|                            | res that tha daath certific<br>igned by the attending p<br>be detached for use as   | <b>by</b> Р      | Part II. Other significant conditions of  | contributing to death bul not                     | resulting in the u                 | underlying               | cause given                 | in Part I.                    | 23e. Did t                           | obacco       | use contribute to            | o the cause   | of death?         |
| ğ                          | w require<br>been sig<br>should b   | edt              |   |   |                                    |                          |                             |                               | 1 🗆                                  | Yes 2        | 12No 3□P                     | robably 4     | □Unknown          |
| Division of Vital Records, | as been<br>2 shouk  | Completed        |   |   |                                    |                          |                             |                               | 24a. Was                             |              | 24b. Were a                  | utopsy findin | gs available      |
| æ                          | The lay<br>ta has<br>aga 2  | mo               |   |   |                                    |                          |                             |                               |                                      | rmed?        | death?                       | completion    | of cause of       |
| ta                         | Physicien: The I<br>this certificeta he<br>ral diractor, paga   | a                | 25. Was case referred to medical  |   |                                    |                          |                             | 26 Place of De                | 1 ☐ Yes<br>ath (Check only o         | 2 N          | 1 ☐ Yes                      | 2 □ No        | · · · · · · · · · |
| >                          | ysici<br>s cer<br>diraci  | To B             | examiner?<br>1 ☐ Yes 2 ☐ No   | Hospital:   | 2 ER/Outpatie                      | nt 3□□                   | Other                       |                               | lome 5 ☐ Resi                        |              | 6 □Other (Soc                | roshe)        |                   |
| 0                          | g Phys<br>er this<br>eral di  |                  | 27. Manner of Death   | 28a. Date of Injury<br>(Month, Day Yea            |                                    |                          | 28c. Injury a<br>Work?      |                               | 28d. Describe                        |              |                              | icity)        |                   |
| <u>0</u>                   | a fun   | at 6             | 1 Accident 5 ☐ Pending 2 ☐ Accident investigation   |   | r) Injury                          | М                        |                             | s 2 No                        |                                      |              |                              |               |                   |
| <u>Vis</u>                 | r Attending P<br>ar death.<br>rector: After<br>by the funera  | HC               | 3 ☐ Suicide 6 ☐ Could not b<br>4 ☐ Homicide determined  | 28e. Place of injury - /                          | At home, farm, st                  | reet, facto              | ry, office                  |                               |                                      |              | nd Number or R               | ural Route N  | lumber,           |
| ō                          | s afta  | Certification:   | - I Homicide  | building, etc. (Sp                                | есігу)                             |                          |                             |                               | City or To                           | wn, Stat     | θ)                           |               |                   |
|                            | To the Hospitel or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death. To the Fureral Director: After this certificeta has been signed by the attending physician end completely filled in by the funeral director, page 2 should be deteched for use as the burial-transit |                  | 29a. Certifier Certifying Pt  | ysinian: To the best of my                        | knowledga, daat                    | th Jonesia               | t at the time,              | , date and plane              | and due to the                       | cause(s      | ) and manner a               | s stated.     |                   |
|                            | he Hk<br>n 24<br>ne Fu<br>yletely   | Medical          | (Check only 2 Medical Examone)  | miner: On the basis of exam<br>and manner stated. | nination and/or in                 | rvestigatio              | n, in my opin               | nion, death occu              | irred at the time,                   | date an      | d place, and due             | e to the caus | e(s)              |
|                            | To the To the Comp  | ž                | 29b. Signature and title of certifier   | Perme IAN   |                                    | 29                       | c. License r                | number                        |                                      |              | ate signed (Mont             | -             |                   |
|                            |   |                  | and if  | ( PU)   |                                    | -                        | Rec                         | 0000                          |                                      | De           | cember,                      | 21,2          | 2005              |
|                            | 10  |                  | 30. Name and address of person who  | completed cause of death                          | Item 23a) (Type,                   | Print)                   |                             |                               |                                      |              |                              |               |                   |
| - 5                        | 12  |                  |   | arma, 900   | o Fran                             | Klin                     | San                         | are ?                         | prive Z                              | 11 20        | posene                       | 10            | 1127              |
|                            | Sta   | te               | 31. Date filed (Month, Day, Year)   | 32. Registrar's S                                 | ignature                           |                          | V                           | ~                             | 4-000                                |              |                              |               |                   |
|                            | Registr   | ar               | 570000  |   | 9.7                                | A .                      | ,                           |                               |                                      |              |                              |               |                   |

CPM 05-8609 Ann Spicer

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) Date of Death
 Month December 18, **Physician** 2005 23:40 Spicer /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1834 Portship Road Dunda1k Baltimore | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | July 20, 1930 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 💢 F 215-28-9400 75 Yrs. Director WV. Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits in than "naturel", or iteme 23a or 28a-f ehow the Medical Examiner must be notified at 1 ☐ Yes 2 X No Director Baltimore Dundalk 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1834 Portship Road 21222 USA permit. Pages 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "naturel", or Iteme 23a eny injury or other traumatic event, the Madical Examples once. Funerai 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black. White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: þ Specify: White 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 years Mail Clerk Postal 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Ethal Kiessling ျှ Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1834 Portship Road, Dundalk, MD. 21222 Daughter Robin Clemsen 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) December 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory Baltimore, MD. 22,2005 21. Signature of Funeral Service Licensee. connelly funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, MD. 21222 23a. Part I. Enter the disease, or complications that caused the death. Doubt enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Alter sclerofic lardipuscular Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). the Hospital or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 Probably 4 €Onknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 1 Yes 25. Was case referred to medical examiner?
1XXes 2 \( \) No Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4  $\square$  Nursing Home 5  $\square$  Residence 6 NOther (Specify) SCENE ို After thi 28a. Date of Injury (Month, Day Year) 27. Manner of Death Certification: 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No Director: 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homicide within 24 hours after To the Funeral Dire 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifi 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. December 21, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201 router 19.0 aviol

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

2005

ORIGINAL

32. Pegistrar's Signature

|  |                  | i icase i   | Otata of Manda  |                                   |                                       |   | _                 | •                            | Jie.                                       |                     |
|--|------------------|---|---|-----------------------------------|---------------------------------------|---|-------------------|------------------------------|--|---------------------|
|  |                  | for State   | State of Marylai                                      | -                                 | irtment of<br><i>tificate of</i>      |   | Mental H          | 200                          | 5 1 1 5                                    | 153                 |
|  |                  | Registrar     Decedent's Name (First, Middle, Last,   | )   | Cer                               | uncate of                             | Dealli  | 2. Date of D      | Reg. No.                     | J 7 Time                                   | e of Death          |
| Physicia   | an               | DORZRT  | F   | <                                 | TECI                                  | TER   | Month<br>Do C     | Day                          | Year _ Q                                   | · CDAM              |
| /Medic<br>Examin   |                  | 4a. Facility Name (If not institution, give   | street and number) PA/T                               | IMARE                             | 4b. City, Town,                       | or Location of Deat                           |                   | 4c. County                   | of Death                                   | J'A                 |
| LXamin   | C1               | VA REHAB & GXTE   | NOED CARE   | CENTER                            |                                       | ALTIMO  |                   | ,                            |  |                     |
| Funeral  |                  | Social Security Number     6. Se  |   | . last birthday)                  | If Under 1 Yea<br>Months Days         | r If Under 24 Hrs                             |                   | irth<br>Day Year)            | 9. Birthplace (Star<br>Country)            | te or Foreign       |
| Director   |                  | 218-14-0934   | M 2□F 8   | 1 Yrs.                            | Wiona io Day                          | 7 10010                                       | 11/2              | orth<br>Oay, Year)<br>0/1924 | M  |                     |
| and<br>w   |                  | Usual Residence of Decedent  10a. State 10b. County   | 10c. C  | ity, Town or Loc                  | cation                                |   |                   |                              | 10d. Inside                                | a City Limits       |
| Maryl<br>f sho   | ō                | MD Anne Ar  | undel   | Pasade                            | na                                    |   |                   |                              |  | es 2 <b>X</b> No    |
| the 728a-  | rect             | 10e. Street and Number  | direct  | asaac                             | 10f. Zip Code                         |   |                   | 10g. Citizen of W            | hat Country?                               |                     |
| h with   | io ie            | 206 Inlet Drive   |   |                                   | 2112                                  | 2   |                   | U.S.                         | Α.   |                     |
| within 72 hours after death with the Maryland<br>ene.<br>than "natural", or Itams 23a or 28a-f show<br>the Madical Examilier must be notified at                 | Funeral Director | 11. Marital Status  | 12. Was Decedent Ever in U                            | J.S. 13. V                        |                                       | Hispanic Origin? (S<br>ban, Mexican, Puer     | Specify Yes or N  | lo- 14. Race                 | - American Indian                          | i,                  |
| or Ita   | y Fu             | 1 Never Married 2 Married   | 1 X Yes 2 □ No 1 9                                    | 43-                               | ☐ Yes 2 No                            |   | to riloan, etc.)  |                              |  |                     |
| hours<br>ural',  | d by             | 3 Widowed 4 Divorced  | Year or Dates: 19                                     | 45                                |                                       |   |                   |                              | White                                      |                     |
| "nat   | Completed        | 15. Decedent's Edu<br>(Specify only highest grad  | cation<br>e completed)                                | 16a. Deced<br>(Give I             | ent's Usual Occu<br>kind of work doni | upation<br>a <i>duri</i> ng most of wo<br>ad) | rking             | 16b. Kind of Bus             | siness/Industry                            |                     |
| withi<br>iene.<br>than   | omp              | Elementary/Secondary (0-12)   | College (1-4or 5+)                                    |                                   | ty Ins                                |   |                   | Coast                        | Guard                                      |                     |
| Hyg<br>other   | Be C             | 17. Father's Name (First, Middle, Last)   |   | ,                                 | 01                                    | -   | me (First, Middl  | e, Maiden Sumame             |  |                     |
| uld be<br>denta<br>rkad<br>tic ev  | To B             | Frederick Sted  | ker   |                                   |                                       | Frede   | ricka             | Birrane                      |  |                     |
| d 2 should be filed within h and Mental Hygiene. 7 Is merked other than traumatic event, the Merked  |                  | 19a. Informant's Name/Relationship (T)  | pe, Print)  | 19b. Mailin                       | g Address (Stree                      | at and Number or R                            | ural Route Num    | ber, City or Town, S         | State, Zip Code)                           |                     |
| 1 and 2<br>Health<br>tem 27 l  |                  | Dorothy Stecker   |   |                                   |                                       | Drive,  | Pasade            | na, MD                       | 21122                                      |                     |
| s = = 0  |                  | 20a. Method of Disposition Entor  |   | Place of Dispos<br>cemetery, crem | sition (Name of<br>natory or other pl | ace)  | Date              | 20c. Location - (            | City or Town, State                        | 1                   |
| permit. Page<br>Department o<br>Important: If<br>any injury or<br>once.  |                  | * 4 □Donation 5 🔀 Other (Specify)   | Ce  |                                   | 11 Cem                                |   | 22/05             | Baltim                       |  |                     |
| permit<br>Depar<br>Impor<br>any in   |                  | 21. Signature of Buneral Service Licens   | 30  |                                   |                                       |   |                   | ce Fune                      |  |                     |
| Ø□ = @ OI  |                  | Mollen  |   |                                   |                                       |   |                   | sadena,                      |  |                     |
| Physician  |                  | 23a. Part1. Enter the disease, or compl<br>shock, or heart failure. List only of<br>Immediate Cause (Final            | ne cause on each line.                                | TIA                               | ar the mode of dy                     | ang, such as cardia                           | c or respiratory  | arrest,                      | Approxin<br>Interval I<br>Onset ar         | Between<br>nd Death |
| /Medical   |                  | disease or condition resulting in death)  | Due to (or as a conse                                 |                                   |                                       |   |                   |                              |  |                     |
| Examiner   |                  | Sequentially list conditions  | 2   |                                   |                                       |   |                   |                              |  |                     |
| ם יו   | iner             | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cat. J. 1999 that initiated events | Due to (or as a conse                                 | quence of):                       |                                       |   |                   |                              |  |                     |
| te be executed<br>ysician and<br>ne burial-transit   | Examiner         | that initiated events<br>resulting in death) Last   | Due to (or as a conse                                 | quence of):                       |                                       |   |                   |                              |  |                     |
| be e)<br>ician<br>buria  | caiE             |   | 200 10 (01 23 2 001130                                | quonos or,                        |                                       |   |                   |                              |  |                     |
| # × 6  |                  |   | J   |                                   |                                       |   |                   |                              |  |                     |
| The law requires that the death certifica to has been signed by the attending phoage 2 should be detached for use as the   | Physician/Med    | IF FEMALE: 23b. Was decedent pregnant   | 3c. If yes, outcome of pregn                          |                                   |                                       |   |                   | 23d. Date                    | of delivery                                |                     |
| death<br>e atte<br>d for   | icia             | in the past 12 months? 1 ☐ Yes 2 ☐ No   | 1 ☐ Live birth 2 ☐ Fet<br>4 ☐ Pregnant at time of     |                                   | Ectopic pregnant<br>Other (specify)   | cy  |                   | Mon                          |  | Year                |
| that the de<br>led by the a<br>detached f  | hys              | 9 🗆 Unknown   | 9□ Unknown  |                                   |                                       |   |                   |                              |  |                     |
| es tha   |                  | Part II. Other significant conditions con   | 0.  | sulting in the un                 | derlying cause g                      | iven in Part I.                               | 23e. Did          | tobacco use contri           | bute to the cause of                       | of death?           |
| v require<br>been si<br>should I   | ted              | Chronic Kid   | ney vize  | se                                |                                       |   | 1 🗆               | Yes 2 No                     | 3 Probably 4                               | Unknown             |
| e faw r<br>has be<br>je 2 sh   | Completed by     | Perspheral i  | Krenlar   | Diz                               | erse                                  |   | 24a. Wa           |                              | ere autopsy findin-<br>ior to completion o | gs available        |
|  | Con              | •   |   |                                   |                                       |   |                   | ormed? de                    | eath?<br>⊒Yes 2∐No                         |                     |
| ysician: Th  | Be               | 25. Was case referred to medical examiner?  | t   |                                   |                                       | 26. Place of De                               | ath (Check only   | one)                         |  |                     |
| Physic<br>this c   | 10               | 1 ☐ Yes 2 ☐ No  27. Manner of Death   | fospital:<br>1 ☐ Inpatient 2 ☐<br>28a. Date of Injury | ER/Outpatient                     | 3 DOA                                 |   |                   | idence 6 Othe                |  |                     |
| ding Pt<br>h.<br>After th<br>funeral   | tion             | Natural 5 ☐ Pending   | (Month, Day Year)                                     | 28b. Time of<br>Injury            |                                       | ork?<br>]Yes 2∐No                             | 28d. Describe     | how injury occurre           | α  |                     |
| for Attendiater death.  Diractor: A  | Certification;   | 3 ☐ Suicide 6 ☐ Could not be  | 28e. Place of Injury - At h                           | nome, farm, stre                  |                                       |   | 28f. Location     | (Street and Numbe            | r or Rural Route N                         | lumber.             |
| after<br>after<br>Dira<br>d in b   | erti             | 4 Homicide  | building, etc. (Speci                                 | ify)                              |                                       |   |                   | own, State)                  |  |                     |
| To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certific completely filled in by the funeral director, |                  | 29a. Certifier 1- Certifying Phy.   | sician: To the best of my kn                          | owledge, death                    | occurred at the                       | time, date and place                          | a, and due to the | cause(s) and man             | ner as stated.                             | Q(e)                |
| To the H<br>within 24<br>To the F<br>complete  | Medical          | 51.07   | and manner stated.                                    | and of HIV                        | γ                                     |   |                   |                              |  |                     |
| or Toon  | -                | 29b. Signature and title of certifier   |   |                                   |                                       | ise number                                    |                   | _                            | (Month, Day, Year                          |                     |
|  |                  |   |   |                                   | 03                                    | -6508<br>4NG/RO<br>BALTII                     | 211               | Dec                          | 18 20                                      | لدنا                |
| 12+1   |                  | 30. Name and address of person who co   | mpleted cause of death (Ite                           | m 23a) (Туре, F                   | rint) X//                             | 41V65/20.                                     | NOS               | HY                           | ) ) . ·                                    | .0                  |
| Sta  | to               | 31. Date filed (Month, Day, Year)   | 22. Registrar's Sign                                  | ature 2CVL                        |                                       | WTL TII                                       | 110116            | 1.16                         | , 6/2                                      | 10                  |
| ાa<br>Registr  |                  | DEC 2 3 2005  | Salva de  | Space                             | K)                                    |   |                   |                              |  |                     |

|                   |  |                     | 1 - For<br>State<br>Registrar  | State  | of Marylan  |                                 | artmen<br><i>rtificat</i> (              |                               |                            | and M                    | -                                    | gieņ<br>Reg. N | 71115                                       | 415                                   | 54                    |
|-------------------|--|---------------------|--|--|---|---------------------------------|--|-------------------------------|----------------------------|--------------------------|--------------------------------------|----------------|---|---------------------------------------|-----------------------|
|                   | Physici  | an                  | Decedent's Name (First, Middle   |  | C' 1  | TTT                             |  |                               |                            |                          | 2. Date of De<br>Month               |                | ay Year                                     | 3. Time o                             | of Death              |
|                   | /Medi  |                     | Gustav   | G.   | Siegel  | , 111                           | T  |                               |                            |                          | Decemb                               | er :           | 17, 2005                                    | 6:07                                  | РМ                    |
|                   | Examir   | er                  | 4a. Facility Name (If not institution  | -  |   |                                 |  |                               | Location of                | of Death                 |                                      |                | C. County of Death                          |                                       |                       |
|                   | Funeral  |                     | Joppa Road & I 5. Social Security Number   | 6. Sex   | 7. Age (In yrs.   | last birthday)                  | If Under                                 | WSON<br>1 Year                | If Under :                 | 24 Hrs.                  | 8. Date of Bir                       | th .           | Baltimore                                   | Place (State                          |                       |
|                   | Director   |                     | 212-38-1190  | 1 <b>火</b> M 2□ F                                | 66  | Yrs.                            | Months                                   | Days                          | Hours                      | Min.                     | 8. Date of Bir<br>Month, Da<br>March | Ž8°,ª          | ″1939 Me                                    | ifyland                               |                       |
|                   | and *  |                     | Usual Residence of Decedent  10a, State 10b, County  |  | 10c Cit   | ty, Town or Lo                  | ocation                                  |                               |                            |                          |                                      |                |   | 10d. Inside (                         | ity Limite            |
|                   | Marylan<br>f ehow  | ō                   |  | .timore  |   | Towso                           |  |                               |                            |                          |                                      |                |   |                                       | 2 No                  |
|                   | 1 28a-   | rect                | 10e. Street and Number   |  |   |                                 | 10f. Zip                                 | Code                          |                            |                          |                                      | 10g. C         | Citizen of What Cou                         | intry?                                |                       |
|                   | th with  | <u>a</u>            | 811 Shelley F  | load   |   |                                 | 2  | 1286                          |                            |                          |                                      | l              | U.S.A.                                      |                                       |                       |
| 36                | ges 1 and 2 should be tiled within 72 hours after death with the Maryland tof Heelih and Mental Hyglene. If Item 27 is marked other than "naturel", or Items 23a or 28s-f show or other traumatic event, I'm Mexical Exacili | by Funeral Director | 11. Marital Status  1 □ Never Married 2 ☐ Mar  3 □ Widowed 4 □ Divorced  | 12. Was De<br>Armed<br>1 Y Yes<br>If Yes, 0      | cedent Ever in U<br>Forces?<br>2 No<br>Give 163-1<br>Dates:         | .s. 13.                         | Was Deced<br>If Yes, spec                |                               |                            | gin? (Spe<br>n, Puerto f | city Yes or No<br>Rican, etc.)       | )-             | 14. Race - Amer<br>Black, White<br>Specify: |                                       |                       |
| 8                 | 2 hou  | ed                  | 15. Deceden  | t's Education                                    |   | 16a. Dece                       | dent's Usua                              | d Occupa                      | ition                      |                          |                                      | 16b.           | Kind of Business/li                         | ndustry                               |                       |
| 21215-0036        | 12 should be tiled within 7.<br>h and Mental Hyglene.<br>7 is marked other than "n.<br>fraumatic event, It's Medi  | Completed           | (Specify only highe<br>Elementary/Secondary (0-12)   |  | d)<br>(1-4or 5+)  | Techn<br>Manag                  | kind of wor<br>DO NOT us<br>11Cal<br>Jer | rk done d<br>Servired<br>Serv | ices                       | t of workir<br>Grou      | p<br>p                               |                | 5/Federal                                   |                                       | rnment                |
| D                 | be tile<br>tal Hy<br>d oth   | Be (                | 17. Father's Name (First, Middle,  |  | ecel II   |                                 |  |                               | 18. Mothe                  |                          | (First, Middle,                      |                |   |                                       |                       |
| З́а               | Menid I<br>Menid I<br>Menid I<br>Menid I<br>Menid I  | ၉                   |  |  | egel, II  | -                               |  |                               |                            |                          |                                      |                | ∩wald<br>                                   |                                       |                       |
| Maryland          | d 2 st<br>th and<br>th and<br>17 te n<br>traun   |                     | 19a. Informant's Name/Relations Gail D. Siegel   |  |   |                                 |  |                               |                            |                          | Route Numbe                          |                | or Town, State, Zi<br>286                   | p Code)                               |                       |
| <u>6</u>          | permit. Pages 1 and 2<br>Department of Heelth a<br>Important: If Item 27 ti<br>eny Injury or other tra<br>90008.   |                     | 20a. Method of Disposition   |  | 20b. F  | Place of Dispo                  | osition (Nan                             | ne of                         | T-                         | D                        | ate                                  | 20c. l         | Location - City or T                        | own, State                            |                       |
| Baltimore,        | Pages<br>sent of<br>int: if it   |                     | 1 XBurial 2 ☐ Cremation<br>4 ☐ Donation 5 ☐ Other (S   |  | II State  | semetery, cre<br>nev Vall       |  |                               | 1                          | 1 <i>2/2</i> 2/          | ∕∩5                                  | Tim            | onium, MD                                   |                                       |                       |
| alti              | permit. Departrr Imports eny Inju  |                     | 21. Signature of Funeral Service   | Licens Wil                                       | liam G.   |                                 | 2. Name an                               | d Addres                      | s of Facility              | yRuck                    | Towso                                |                | uneral Ho                                   | ome, Ir                               | 10.                   |
| <u> </u>          | 89 = 9   |                     | MM   |  |   | 1                               | 050 Y                                    | ork                           | Rd.,                       | Tows                     | on, MD                               | 2′             | 1204  |                                       |                       |
|                   | Physician<br>/Medical  |                     | 23a. Part1. Enter the disease, or<br>shock, or heart failure. List<br>Immediate Cause (Final<br>disease or condition<br>resulting in death)                | a  | t caused the deat<br>n each line.<br>UMP (Cure<br>o (or as a conseq | 5 D                             | ter the mod                              | e of dying                    | , such as                  | cardiac oi               | respiratory ai                       | rrest,         |   | Approxima<br>Interval Be<br>Onset and | tween                 |
| 8760, p           | sate be executed axion by sicien and the burial-transit or   | dical Examiner      | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | c  | o (or as a conseq   |                                 |  |                               |                            |                          |                                      |                |   |                                       |                       |
| O. Box 6          | The law requires that the death certificate be executed to the seen signed by the attending physicien and bage 2 should be detached for use as the burial-transit  | Physician/Med       | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □Yes 2 □ No 9 □ Unknown   | 1□Live   | outcome of pregna<br>birth 2   Feta<br>gnant at time of d<br>known  | Ideath 3                        | Ectopic pro                              |                               |                            |                          |                                      |                | 23d. Date of deliving Month                 |                                       | Year                  |
| rds, P.           | quires that<br>an signed b<br>iuld be deta   | ρ                   | Part II. Other significant condition   | ons contributing to                              | death but not res   | ulting in the u                 | nderlying ca                             | ause give                     | n in Part I.               |                          | 23e. Did to                          |                | use contribute to                           | the cause of                          |                       |
| of Vital Records, |  | Completed           |  |  |   |                                 |  |                               |                            |                          |                                      |                | death*                                      | opsy findings<br>ompletion of a       | available<br>cause of |
| /ita              | iclen: Th<br>certificate<br>rector, pag  | Be                  | 25. Was case referred to medica examiner?  |  |   |                                 |  | 1 00                          |                            | of Death                 | Check only o                         | one)           |   |                                       |                       |
| of                | Phys<br>this<br>aldii  | 2                   | 1X Yes 2 □ No<br>27. Manner of Death   |  |   | ER/Outpatier                    |  |                               | 4 LINUI                    |                          |                                      |                | <b>X</b> ⊠Other (Speci                      | w at s                                | cene                  |
|                   | ding<br>h.<br>Atter<br>fune  | to<br>Lo            | 1 □Natural 5 □ Pendir<br>2 □ Accident investi  | 3  | e of Injury<br>onth, Day Year)                                      | Injury                          | CM                                       | 8c. injury<br>Work            | es 2                       |                          | 8d. Describe t                       |                | GAR STRU                                    | 44. 10.44                             | ACADA -               |
| Division          | or Attending<br>after death.<br>Director: Atter<br>in by the fune  | Certification;      | 3 ☐ Suicide 6 ☐ Could  | not be 28e. Pla                                  | ce of Injury - At he  | ome, farm, sti                  |  |                               |                            |                          | 8t. Location (5                      | Street a       | and Number or Rur                           |                                       |                       |
| ă                 | s after<br>of Direct   | Sert                | 4 ☐ Homicide   | bui  | Iding, etc. (Specif   |                                 |  |                               |                            | So                       | City or Tov                          |                | io)<br>Incurrid to                          | wene L                                | 10                    |
|                   | To the Hospital or Atten within 24 hours after deat To the Funerel Director: completely tilled in by the   | edical              | 29a. Certifier 1 Certifyir (Check only one)  | ng Physician: To t<br>Examiner: On the<br>and ma | he best of my kno<br>basis of exa <i>m</i> ina<br>anner stated.     | owledge, deat<br>tion and/or in | h occurred a<br>vestigation,             | at the tim<br>in my op        | e, date and<br>inion, deat | d place, a               | nd due to the                        | cause/         | s) and manner as                            | tated                                 |                       |
|                   | To t<br>To t   | Σ                   | 29b. Signature and title of certifie   | r ()   | 1   |                                 |  | . License                     |                            |                          | !                                    |                | ate signed (Month,                          |                                       |                       |
| •                 |  |                     | Mayonte  | Thel   | Kell 1  | w                               | 0  | .C.M                          | . L.                       |                          |                                      | Jece           | ember 18,                                   | 2005                                  |                       |
|                   | 10+1   |                     | 30. Name and address of person   | D. KO?   | 20U   | 11                              |  | n St                          | reet,                      | Bal                      | timore,                              | , Ma           | ryland                                      | 21201                                 |                       |
|                   | Sta<br>Registr   |                     | 31. Date filed (Month, Day, Year)  | 1 6  | Registrar's Signa   | iture                           | Market D                                 |                               |                            |                          |                                      |                |   |                                       |                       |

|                            |   |               | 1 _ For State  | State of M   | /laryland /                                 | Depa                    | artment of F<br>ctificate of                 | lealth an                           | d Mental H                                  | ž.            | . 0 0 1                     | 5 1                       | +1555                                     |
|----------------------------|---|---------------|--|--|---|-------------------------|--|-------------------------------------|---|---------------|-----------------------------|---------------------------|---|
|                            |   |               | Registrar  1. Decedent's Name (First, Middle,                            | Last)  |   | 061                     | incate of                                    | Deaiii                              | 2. Date of D                                | Reg. N        | No.                         |                           | 3. Time of Death                          |
| 1                          | Physic  |               | Margaret   |  | Smith                                       |                         |  |                                     | Decem                                       |               | <sup>Day</sup> 22, 2        | Year<br>2005              | 4:00 a M                                  |
|                            | /Medi<br>Examir   |               | 4a. Facility Name (If not institution,                                   | give street and numbe  |   |                         | 4b. City, Town, o                            | or Location of D                    |   |               | 4c. County of               |                           | 4.00 a                                    |
| ı                          |   |               | 1154 Gypsy Lane  | 9  |   |                         | Towson                                       |                                     |   |               | Balti                       | more                      |   |
|                            | Funeral   |               |  | . Sex 7. A<br>1 □ M 2 X F                                      | Age (In yrs. last I                         | "                       | If Under 1 Year<br>Months Days               | If Under 24<br>Hours                | Hrs. 8. Date of B                           | ay, Yea       | ar)                         | Coun                      | lace (State or Foreigr                    |
|                            | Director  |               | 219-30-3118 Usual Residence of Decedent                                  | 16.10 2021   | 96  | Yrs.                    |  |                                     | March 2                                     | 23,           | 1909                        | Nort                      | h Carolina                                |
|                            | land<br>ow  |               | 10a. State 10b. County   |  | 10c. City, To                               | wn or Lo                | cation                                       |                                     |   |               |                             | 10                        | Od. Inside City Limits                    |
|                            | Man)  | to            | Maryland Balti   | .more  | Tows  | OD                      |  |                                     |   |               |                             |                           | 1 ☐ Yes 2 X No                            |
|                            | th the<br>or 28¢  | Directo       | 10e. Street and Number   |  |   |                         | 10f. Zip Code                                |                                     |   | 10g. C        | Citizen of W                | /hat Coun                 | try?                                      |
|                            | ath wi  |               | 1154 Gypsy Lane  | East   |   |                         | 21 286-                                      | 1462                                |   |               | USA                         |                           |   |
|                            | er de   | Funeral       | 11. Marital Status   | 12. Was Deceder<br>Armed Forces                                | 5?  | 13. V                   | Vas Decedent of H<br>Yes, specify Cuba       | lispanic Origin'<br>an, Mexican, P  | ? (Specify Yes or Nuerto Rican, etc.)       | 10-           |                             | - America                 | an Indian,<br>etc.                        |
| 36                         | s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. item 27 is marked other than "natural", or Items 23a or 28e-f show other traumatic event, the Medical Examinal must be multired at | by F          | 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced                   | d 1 ☐ Yes 21 <b>X</b><br>If Yes, Give<br>Year or Dates         |   |                         | ∏Yes 2√∑No                                   | Specify:                            |   |               | Specify:                    |                           | ite                                       |
| Maryland 21215-0036        | 2 hou<br>atura  |               | 15. Decedent's   | Education  |   | a. Deced                | ent's Usual Occup                            | ation                               |   | 16b.          | Kind of Bus                 | siness/Ind                | lustry                                    |
| 215                        | within 7<br>ene.<br>than "n   | Completed     | (Specify only highest Elementary/Secondary (0-12)                        | grade completed) College (1-4ol                                | r 5+)                                       | (Give l                 | kind of work done<br>OO NOT use retired      | during most of<br>d)                | working                                     |               |                             |                           |   |
| 7                          | filed withi<br>Hygiene.<br>other than<br>ent, the M   | Con           | 12   |  |   | Co Oi                   | nuer   |                                     |   | H'            | VAC B                       | usine                     | ess                                       |
| and                        | be fil<br>ntal H<br>od oth  | Be            | 17. Father's Name (First, Middle, La<br>William Aaron F                  |  |   |                         |  |                                     | Name (First, Middle                         |               | en Sumame                   | e)                        |   |
| 100                        | should be<br>nd Mental<br>marked o  | 2             | 19a. Informant's Name/Relationship                                       |  |   |                         |  | Beula                               |   |               |                             |                           |   |
| Ma                         | d 2 sho<br>th and<br>t7 is mu<br>traum  |               |  |  |   |                         |  |                                     | r Rural Route Numi                          |               |                             |                           | 120                                       |
| ē,                         | s 1 and 2<br>of Health<br>item 27<br>other tre  |               | Jacqueline Perk 20a. Method of Disposition                               | ins/daught   | 20b. Place                                  | of Dispos               | sition (Name of                              |                                     | ad, Luthe                                   |               | lle. [<br>Location - C      |                           | 21 093<br>vn. State                       |
| JOE I                      | 0 0   |               | 1 ⊠ Burial 2 ☐ Cremation 3  1 4 ☐ Donation 5 ☐ Other (Spe                |  | er  |                         | atory or other place.                        |                                     | /27/2005                                    |               |                             |                           |   |
| Baltimore,                 | permit. Pag<br>Department<br>Important: I<br>any injury o   |               | 21. Signar re of Euneral Service Lic                                     |  | Data  |                         |  |                                     | Ruck Tows                                   | 000           | rinonic                     | JM, IV                    | laryland                                  |
| Ä                          | Par in De   |               | Mulo   | ' Step   | hen Cost                                    | ter                     | 1050 Yo                                      | ork Rd.                             | , Towson,                                   | תM<br>ו ווטי  | 21.21                       | 17<br>1                   | ome, inc.                                 |
|                            |   |               | 23a. Part1. Enter the disease, or co<br>shock, or heart failure. List on | emplications that cause<br>by one cause on each                | ed the death. Do                            | not ente                |  |                                     |   |               |                             |                           | Approximate<br>Interval Between           |
|                            | Physician :   |               | Immediate Cause (Final disease or condition                              | , di   | emention                                    | 4                       |  |                                     |   |               |                             |                           | Onset and Death                           |
|                            | /Medical<br>Examiner  |               | resulting in death)  | Due to (or a   | s a consequence                             | e of):                  |  |                                     |   |               |                             |                           | 700                                       |
|                            | Ladillilici   | _             | Sequentially list conditions, if any, leading to immediate               | b. Due to (or a  | s a consequence                             | n of).                  |  |                                     |   |               |                             | -                         |   |
| 2                          | nsit  | Examine       | cause. Enter Underlying<br>Cause (Disease or injury                      | D08 10 (01 a   | s a consequence                             | 5 01).                  |  |                                     |   |               |                             |                           |   |
| ,                          | ificate be executed<br>g physician and<br>as the burial-transit   | Еха           | that initiated events<br>resulting in death) Last                        | c<br>Due to (or a  | s a consequence                             | e of):                  |  |                                     |   |               |                             | -                         |   |
| 68760,                     | te be<br>ysicia<br>ne bur   | edlcai        |  | d  |   |                         |  |                                     |   |               |                             |                           |   |
|                            | ± og g  | Medi          | IF FEMALE.   |  |   |                         |  |                                     |   |               |                             | 7                         |   |
| Вох                        | that the death certif<br>ed by the attending<br>detached for use a  | an/M          | IF FEMALE: 23b. Was decedent pregnant in the past 12 months              | 23c. If yes, outcom<br>1 ☐ Live birth                          | e of pregnancy<br>2 Detail deat             | h 3 🗆                   | Ectopic pregnancy                            | ,                                   |   | 1             | 23d. Date                   |                           | *   |
| 0.                         | o o   | hysici        | 1 Yes 2 No   | 4□Pregnant a<br>9□ Unknown                                     | at time of death                            |                         | Other (specify)                              |                                     |   |               | Mont                        | in L                      | Day Year                                  |
| P.O.                       | requires that the<br>leen signed by th<br>hould be detache  | Ω             | Part II. Other significant conditions                                    | s contributing to death  | but not resulting                           | in the un               | derhina cauca an                             | on in Part I                        | 23a Did                                     | tobacco       | uca contrib                 | nuto to the               | cause of death?                           |
| Division of Vital Records, | es<br>pe  | d by          | he nothe ned   | 544  | Dat Hot roodining                           | an tho un               | obitying cause give                          | on in tout 1,                       |   |               |                             |                           | bly 4 Unknown                             |
| COL                        | > 10 0  | ete           | his on all of  | ,, -,  |   |                         |  |                                     | 24a. Was                                    |               |                             |                           |   |
| Re                         | e fa<br>has<br>je 2   | ompleted      | - My Proposition   |  |   |                         |  |                                     | <ul> <li>auto</li> <li>perfe</li> </ul>     | psy<br>ormed? | pri                         | ior to come<br>ath?       | sy findings available pletion of cause of |
| ta                         | iclan: Th<br>certificate<br>rector, pag   | C             | 25. Was case referred to medical   |  |   |                         |  | 26 Place of I                       | 1 ☐ Yes<br>Death (Check only                | 2 DK          | 0 1                         | Yes 2                     | 2 □ No                                    |
| Ξ                          | Physiclan:<br>r this certific<br>ral director,  | O B           | examiner?<br>1 □ Yes 2 ☑ No  | Hospital: 1 ☐ Inpat  | ient 2 ER/C                                 | utpatient               | 3□ DOA Oth                                   | 00                                  | g Home 5 sesi                               |               | 6 Other                     | (Specify)                 |   |
| 0                          | iding Phys<br>th.<br>After this (<br>funeral dir  | n: T          | 27. Manner i Death 1 Vatural 5 ☐ Pending                                 | 28a. Date of Inj<br>(Month, D                                  | ury 28b.                                    | Time of<br>Injury       | 28c. Injun<br>Worl                           |                                     | 28d. Describe                               |               |                             |                           |   |
| <u>0</u>                   | endir<br>sath.<br>or: Af<br>he fu   | atic          | 2 Accident investigat  | ion  | -, , , , ,                                  | ,,                      |  | Yes 2 □ No                          |   |               |                             |                           |   |
| Ĭ<br>Ž                     | or Attendate death Director: /  | ertification; | 3 Suicide 6 Could not 4 Homicide   | d 286. Place of In   | njury - At home, f<br>etc. <i>(Specify)</i> | arm, stre               | et, factory, office                          |                                     | 28f. Location (<br>City or To               |               |                             | or Rural                  | Route Number,                             |
| /                          | pital o   | O             | 20- Carting 1NG-vision   | <b>1</b>   |   |                         |  |                                     |   |               |                             |                           |   |
| )                          | To the Hospital or Attending P within 24 hours after death. To the Funeral Director: After t completely filled in by the funera   | edical        | 29a. Certifier 1 Certifying 1 (Check only one) 2 Medical Ex              | Physician: To the besi<br>aminer: On the basis<br>and manner s | of examination a                            | je, death<br>nd/or invi | occurred at the time<br>estigation, in my of | ne, date and pla<br>pinion, death o | ace, and due to the<br>ccurred at the time, | date an       | s) and manr<br>id place, an | ner as sta<br>id due to t | ted.<br>he cause(s)                       |
|                            | To the within 2 To the complet  | Me            | 29b. Signature and title of certifier                                    |  |   |                         | 29c. License                                 | number                              |   | 29d. Da       | ate signed (                | (Month, D                 | ay, Year)                                 |
|                            | F > F 0   |               | Han Je   | ing m  |   |                         | 1757   | 169                                 |   | De            | cerbe                       | 22,                       | 2005                                      |
|                            | iΧ  |               | 30. Name and address of person wh  | o completed cause of   |   |                         | Print)                                       |                                     |   |               |                             | ι                         |   |
|                            | 10  |               | 17   | 40 6701  | N-Char                                      |                         | it. #510                                     | T                                   | owsan, M.                                   | 2             | 1204                        |                           |   |
|                            | Sta   |               | 31. Date filed (Month, Day, Year)  | 2005 32. Rêgist  | rar's Signature                             | 100                     | 100 mg                                       |                                     |   |               |                             |                           |   |
| DH                         | Registr   |               | DEC 6 0  | LUUJ Jakar   | Had J.                                      | and the said of         |  |                                     |   |               |                             |                           | 100-10                                    |
| ᄱ                          | MH 17 Rev 1/20  | JU 1          |  |  |   |                         |  |                                     |   |               |                             |                           |   |

Amend Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend Item #20b&c Per Ana Bd C851 1/18/06 Jh
State of Maryland / Department of Health and Mental Hygiene 1- State Registrar Amend Item #22 Per FH C850 997 1959 165 of Peath 1. Decedent's Name (First, Middle, Last) 2. Date of Death 18, 2005 December Daniel Sprezian, Sr. 5:02PM M 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 11345 Pulaski Highway White Marsh Baltimore

Physician

/Medical

Examiner

|            | Funeral Director   |                               | 213-32-5031 Usual Residence of Decedent   | 1 X M 2 □ F 6   | 9 Yrs.                                   | Months Days   | Hours Min. B. Date of Month, MAY  | 5 1936  | Birthplace (State or Foreign Country)     MD                         |
|------------|--|-------------------------------|---|---|--|---|---|---|--|
|            | land   |                               | 10a. State 10b. County  | 10  | Oc. City, Town or Loc                    | cation  |   |   | 10d. Inside City Limits  |
|            | death with the Maryland<br>ms 23a or 28a-1 ehow  | ctor                          | MD Balti  | more  | White                                    | Marsh   |   |   | 1 □Yes 2 XNo   |
|            | or 28  | lrec                          | 10e. Street and Number  |   |  | 10f. Zip Code   |   | 10g. Citizen of W   | /hat Country?  |
|            | ath wi   | rai                           | 11345 Pulaski   |   |  | 2116  |   | USA   | A  |
|            | or Ita   | Completed by Funeral Director | 11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☐ Widowed 4 ☐ Divorced   | 12. Was Decedent Eve<br>Armed Forces?<br>1 X Yes 2 ☐ No<br>If Yes, Give<br>Year or Dates: | If                                       | Vas Decedent of His<br>Yes, specify Cuban                   | panic Origin? (Specify Yes or<br>n, Mexican, Puerto Rican, etc.)<br>Specify:                          | No- 14. Race<br>Blace<br>Specify                                  | e American Indian,<br>k, White, etc.<br>White                        |
| 21215-0036 | "natural",   | ed                            | 15. Decedent's I  | Education   |  | ent's Usual Occupa  | tion  | 16b. Kind of Bu   |  |
| 215        | nn 7.  | pie                           | (Specify only highest g<br>Elementary/Secondary (0-12)  | rade completed)  College (1-4or 5+)   | (Give I                                  | kind of work done du<br>OO NOT use retired)                 | tion<br>uring most of working   | 105.11.100.00   | oniodanidudity   |
| 2          | 2 should be tiled within and Mental Hygiene. Is marked other than raumatic event. The M.   | Con                           | 12  |   | Cab                                      | Driver  |   | Transp  | portation  |
| Maryland   | d oth  | Be                            | 17. Father's Name (First, Middle, Las   |   |  |   | 18. Mother's Name (First, Midd  |   | 9)   |
| y∃a        | Men<br>Men<br>Marke  | ၉                             |   | ezian   |  |   |   | htwell  |  |
| Nar        | 2 sho  |                               | 19a. Informant's Name/Relationship  |   |  |   | nd Number or Rural Route Num  |   |  |
|            | 1 and 2<br>Health<br>tem 27 l  |                               | Rhonda Thornt 20a. Method of Disposition  |   | 10 /412<br>20b. Place of Dispos          |   | cricia Ct. D  |   |  |
| Baltimore, | permit. Pages 1 and Department of Healt Important: If Item 2 any injury or other 2000.   |                               | 1 Burial 2 Cremation 3  | Removal from State  |  | Try o'VETO  | - 12/26/2005  | Owings  | City or Town, State  Mills Md  |
| Balt       | permit. Pa<br>Departmen<br>Important:<br>any injury<br>once.   |                               | 21. Signature of Funeral Service Lice 23a. Part1. Enter the disease, or conshock, or heart failure. List ont  | ensee Heather (   | Cain e                                   | VFA Steph   | of Fabity Lordinand, P  | A. Ruck,  | Inc.   |
| -          | N  |                               | 23a. Part1. Enter the disease, or cor   | mplications that caused the   | death. Do not ente                       | 8717 Gre  | Pastures Dr   | ive Towso   | n, MD 21286  |
|            | Physician  | i                             |   | y one cause on each line.   | -(                                       | 1 74  | 2 0   |   |  |
|            | /Medical   |                               | disease or condition resulting in death)  | Due to (or as a co  | cardence of):                            | me of his   | e   |   | 14 MON41   |
| *          | Examiner   |                               |   | ,   |  | Ø .   |   |   |  |
| , S        | P =  | ner                           | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury   | Due to (or as a co  | onsequence of):                          |   |   |   |  |
|            | ecute<br>ind<br>trans  | Examiner                      | that initiated events   | c   |  |   |   |   |  |
| 60,        | be exe<br>icien a<br>burial-   | al Ex                         | resulting in death) Last  | Due to (or as a co  | onsequence of):                          |   |   |   |  |
| 68760,     | tificate<br>g phys<br>as the   | edic                          |   | d   |  |   |   |   |  |
| P.O. Box   | w requires that the death certificate be executed to be en signed by the attending physicien and should be detached for use as the burial-transit                | pieted by Physician/Medical   | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown   | 23c. tf yes, outcome of p<br>1 ☐ Live birth 2 ☐<br>4 ☐ Pregnant at timi<br>9 ☐ Unknown    | Fetal death 3                            | Ectopic pregnancy<br>Other (specify)                        |   | 23d. Date<br>Mon  | of delivery<br>th Day Year   |
| ٥.         | s that I   | y Ph                          | Part II, Other significant conditions   | contributing to death but no  | ot resulting in the un                   | derlying cause giver  | in Part I, 23e. Did   | d tobacco use contri  | bute to the cause of death?  |
| cords,     | w requires (   | ed b                          |   |   |  |   | 140   | ∃Yes 2□No   | 3 ☐ Probably 4 ☐ Unknown   |
|            |  | piet                          |   |   |  |   | 24a. Wt   |   | ere autopsy findings available                                       |
| Vital Re   | The<br>ate h<br>page   | Com                           |   |   |  |   |   | formed? de  | lor to completion of cause of<br>eath?<br>□ Yes 2\=\n\o              |
| /ita       |  | -                             |   | 10.00   |  |   |   |   |  |
| <b>d</b>   | clan:<br>ertitic   | Be                            | 25. Was case referred to medical examiner?  |   |  |   | 26. Place of Death Check only   | 200   |  |
|            | hysician: The ta<br>this certiticate ha<br>al director, page 2   | To B                          | examiner? 1 Yes 2 No  | Hospital: 1 ☐ Inpatient   | 2 ER/Outpatient                          | Other   |   | -   | r (Specify)  |
| sion o     | Phys<br>this<br>al dii   | To B                          | examiner?  1 Yes 2 No  27. Manner of Death  1 Natural 5 Pending 2 Accident investigation  | 28a. Date of Injury (Month, Day Ye  |  | 3 DOA Other<br>28c. Injury a<br>Work?                       | 4 ☐ Nursing Home 5 ■Re  | -   |  |
| Division   | ial or Attending Physician;<br>s after death.<br>al Director: After this certific<br>ad in by the funeral director.  | To B                          | examiner? 1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending   | 28a. Date of Injury (Month, Day Ye  | 28b. Time of Injury  At home, farm, stre | 3 DOA Other  28c. Injury a Work?  M 1 Ye                    | 4 Nursing Home 5 Re at 28d. Describe as 2 No  | sidence 6 🗆 Other   |  |
| Division   | Hospital or Attending Physician: 24 hours after death     Funeral Director: After this certific letely filled in by the funeral director.                        | Certification: To B           | examiner?  1 Yes 2 No  27. Manner of Death  1 Natural 5 Pending investigatic investigatic determined  2 Accident 6 Could not 1 determined   | 28a. Date of Injury (Month, Day Ye  28e. Place of Injury building, etc. (S                | At home, farm, stre                      | 3 DOA Other 28c. Injury & Work? M 1 Ye et, factory, office  | 4 Nursing Home 5 Re at 28d. Describe as 2 No  | sidence 6 Others how injury occurre (Street and Numberown, State) | d<br>r or Rural Route Number,  |
| Division   | To the Hospital or Attending Physician: To the Funeral Director: Alter this centific completely filled in by the funeral director.                               | To B                          | examiner?  1 Yes 2  No  27. Manner of Death  1 Natural 5 Pending investigation of Could not I determined  2 Accident investigation of Could not I determined  29a. Certifier (Check only)  29 Medical Example 1 | 28a. Date of Injury (Month, Day Ye  28e. Place of Injury building, etc. (S                | At home, farm, stre                      | 3 DOA Other 28c. Injury & Work? M 1 Ye et, factory, office  | 4 Nursing Home 5 Re at 28d. Describe as 2 No 28f. Location City or T                                  | sidence 6 Others how injury occurre (Street and Numberown, State) | d<br>r or Rural Route Number,  |
| Division   | To the Hospital or Attending Physician, within 24 hours after death.  To the Funeral Director: After this certific cumpletely filled in by the funeral director. | Certification: To B           | examiner?  1 Yes 2 No  27. Manner of Death  1 Natural 5 Pending investigatic investigatic determined  2 Accident 6 Could not 1 determined  29a. Certifier (Check only one)  1 Certifyin P 2 Medical Examined    | 28a. Date of Injury (Month, Day Ye  28e. Place of Injury building, etc. (S                | At home, farm, stre                      | 3 DOA Other  28c. Injury a Work?  M 1 Yeet, factory, office | 4 Nursing Home 5 Re at 28d. Describe as 2 No 28f. Location City or T tion, death occurred at the time | sidence 6 Others how injury occurre (Street and Numberown, State) | or or Rural Route Number,  The act stated,  Indicate to the cause(s) |

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

DEC 2 3 2005

2. Registrar's Signature

Pt. Kuown as Brady Sullivall, Maryland 21215-0036

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|---|------------------|---|--|--|-------------------------|---------------------------------|--|--|---|--------------------------|---------------------------------|--|
|   |                  | for State   |  | State of Ma  | arylan                  |                                 |  |  | Mental Hy                               | ygiene                   | nns                             | 1.1557   |
|   |                  | Registrar   | (PP)                                   |  |                         | Ce                              | rtificate of   | Death                                    |   | Reg. No                  | 000                             | 41001  |
| Physici   | an               | 1. Decedent's Nam   | A D                                    | .5' I  | 11                      | 1 11                            | 1AN  |  | 2. Date of D                            | . Da                     |                                 | 3. Time of Death                                   |
| /Medic<br>Examin  |                  | 4a. Facility Name   | (If not institution, c                 | rive street and number)  |                         | - 17                            | 4b. City. Town.  | or Location of Dea                       | Dece                                    |                          | County of Dea                   |  |
| Exami   | er               | Sina  | 11 -01                                 | tal of Ba  | 144                     | nove                            | Bal  | Hmon                                     |   | 10.                      | . Godiny of Boa                 | ui   |
| Funeral   |                  | 5. Social Security !  | Number 6.                              |  | e (In yrs.              | last birthday)                  | If Under 1 Year<br>Months Days   | * *                                      | S. 8. Date of B                         | irth                     | 9. Bir                          | thplace (State or Foreign                          |
| Director  |                  | 423-36-6<br>Usual Residence   |  | 10 <b>3</b> M 2LIF   | 74                      | Yrs.                            | Montals Bays   | 1100.0                                   | (Month, D                               | 4/193                    | 31 AL                           |  |
| land<br>ow  |                  | 10a. State  | 10b. County                            |  | 10c. City               | y, Town or Lo                   | cation   |  |   |                          |                                 | 10d. Inside City Limits                            |
| Many<br>a-f sh  | tor              | MD  |  |  | Bal                     | timore                          | •  |  |   |                          |                                 | 17⊒¥Yes 2 □ No                                     |
| th the<br>or 28;  | )irec            | 10e. Street and Nu  | ımber                                  |  |                         |                                 | 10f. Zip Code  |  |   | 10g. Cit                 | izen of What Co                 | ountry?  |
| ath w   | ral              | 5715 Pa:  | rk Heigh                               | ts Ave. Apt  | . 71                    |                                 | 21215  |  |   |                          | ted Sta                         | tes  |
| ltems   | Funeral Director | 11. Marital Status  | ried 2⊡ Married                        | 12. Was Decedent I<br>Armed Forces?<br>1  Yes 2                  |                         | S. 13.                          | Was Decedent of H<br>If Yes, specify Cub   | lispanic Origin? (<br>an, Mexican, Pue   | Specify Yes or N<br>ito Rican, etc.)    | 0-                       | 14. Race - Ame<br>Black, White  |  |
| be filed within 72 hours after death with the Maryland Ital Hygiene. Ital Hygiene. Ital of other than "naturel", or Items 23a or 28a-f show event. It a Madical Evaryiner must be motified at   | by               | 3 Widowed   |  | If Yes, Give<br>Year or Dates:                                   | 40                      |                                 | 1□Yes 2⊉√√0  | Specify:                                 |   |                          | Specify:Bla                     | .ck  |
| 72 hor  | Completed        | (Sne  | 15. Decedent's<br>acify only highest g | Education  |                         | 16a. Dece                       | dent's Usual Occup<br>kind of work done  | pation                                   |   | 16b. K                   | ind of Business                 |  |
| ithin ne.   | npie             | Elementary/Seco   |  | College (1-4or 5   | +)                      | life.                           | DO NOT use retire  | d) most of we                            | nking                                   | Hos                      | pitalit                         | Y  |
| iled w<br>Tygier<br>ther tl   |                  | 6<br>17. Father's Name  | (First Middle 1 a                      | et)  |                         | Maint                           | enance   | 10 14-41-4-1-1                           |   | 14-7-                    | 0                               |  |
| d be f<br>antal h   | Be               |   | Sullivan                               | 51/  |                         |                                 |  | Mary C                                   | me <i>(First, Middle</i><br>ollins      | e, Maiden                | Sumame)                         |  |
| shoul<br>nd Me<br>mark  | To               | 19a. Informant's N  | lame/Relationship                      | (Type, Print)  |                         | 19b. Mailir                     | ng Address (Street   |  |   | ber. City o              | r Town, State, 2                | Zip Code)  |
| alth a  |                  | Linda Mae   | e Johnson,                             | /Friend  |                         |                                 |  |  |   | -                        |                                 | more, MD 21  |
| permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturel", or Items 23a or 28a-1 show eny injury or other treumatic event. It a Medical Examinating the milling at once.                                 |                  | 20a. Method of Dis  |  | ☐Removal from State  | 20b. P                  | lace of Dispo<br>emetery, crer  | sition (Name of<br>matory or other pla   | сө)                                      | Date<br>Dec 20                          | 20c. Lo                  | ocation - City or               | Town, State  |
| Pag<br>ment<br>lant: I  | 7                |   | 5 Other (Spec                          |  | Che                     | sapeal                          | ce Cremat  | ory Inc.                                 |   | Belt                     | sville,                         | Maryland   |
| permit<br>Depart<br>Import<br>eny in  |                  | 21. Signature of Fi   | uneral Service Lic                     | ensee  |                         | 22<br>C:                        | Name and Address   | ss of Facility<br>and Funer              | al Altern                               | native                   | es                              |  |
| 40260   |                  | 232 Page Pater  | the disease of an                      | mplications that caused  | 0140                    |                                 |  |  |   |                          | more, Ma                        | ryland 21286-                                      |
|   |                  | shock, or hea   | art failure. List offi                 | ly one cause on each lin   | 10.                     | . Do not ont                    | er the mode or dyli  | g, such as cardia                        | c or respiratory a                      | arrest,                  |                                 | Approximate<br>Interval Between<br>Onset and Death |
| Physician /<br>/Medical   |                  | disease or condition resulting in death)                            | on                                     | a. Due to (or as a   | LC<br>a consequ         | 1710                            | ma 1   | J-LU                                     | ng                                      |                          |                                 | 3 years  |
| Examiner  |                  |   |  |  | u 001100qt              | 201100 017.                     |  | V  | V                                       |                          |                                 |  |
| ₽ ≃   | ner              | Sequentially list co<br>if any, leading to in<br>cause. Enter Under | onditions,<br>nmediate<br>erlying      | b. Due to (or as a   | a consequ               | uence of                        |  |  |   |                          |                                 |  |
| be executed<br>ician and<br>burial-transit  | Examiner         | Cause (Disease or<br>that initiated events<br>resulting in death)   | r injury                               | c  |                         |                                 |  |  |   |                          |                                 | <u> </u>   |
| be ex<br>ician<br>burial  | =                | , and a second  |  | Due to (or as a  | a consequ               | ience of):                      |  |  |   |                          |                                 |  |
| ficate I<br>physi   | edica            |   |  | d  |                         |                                 |  |  |   |                          |                                 |  |
| To the Hospitel or Attending Physician: The law requires that the death certificate twithin 24 hours after death. Within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physic completely filled in by the funeral director, page 2 should be detached for use as the b | D/Me             | IF FEMALE:<br>23b. Was deceden                                      | nt pregnant                            | 23c. If yes, outcome   |                         |                                 |  | -  |   | 2                        | 23d. Date of del                | verv   |
| death<br>e atte   | Physician/M      | in the past 12<br>1 Tes 2   | 2 months?                              | 1□Live birth 4□Pregnant at                                       |                         |                                 | Ectopic pregnancy<br>Other <i>(specify)</i>  | /<br>                                    |   |                          | Month                           | Day Year   |
| that the de<br>led by the a<br>detached i   | hys              | 9 🗆 Unknown   |  | 9□ Unknown   |                         | 111                             |  |  |   |                          |                                 |  |
| w requires tha<br>been signed I<br>should be det  | by               | Part II. Other signi  | ficant conditions                      | contributing to death bu   | it not resu             | ulting in the ur                | nderlying cause giv  | en in Part I.                            |   |                          |                                 | the cause of death?                                |
| requi   | eted             | - Dyvin   | my sen                                 | / 22   |                         |                                 |  |  | 102                                     | Yes 2L                   | _No 3 Pr                        | obably 4 Unknown                                   |
| has by  | Completed        | TYP   | one                                    | MSLON  |                         |                                 | -  |  | 24a. Was                                |                          | 24b. Were au<br>prior to death? | topsy findings available completion of cause of    |
| ician: The<br>certificate ha  | e Co             | 25. Was case refer  | rred to medical                        |  |                         |                                 |  |  | 1□ Yes                                  | 2 No                     |                                 | 2 No   |
| ysician:<br>is certific<br>director,  | To Be            | examiner?   |  | Hospital: 1 Inpatier   | nt 21/1                 | ER/Outpatien                    | t 3 DOA Oth  |  | ath <i>Check onl</i> d<br>dome 5 ☐ Resi |                          | Othor (Spec                     | 16.1   |
| g Phys<br>ter this<br>neral di  |                  | 27. Manner of Deat  |  | 28a. Date of Injur<br>(Month, Day                                | y                       | 28b. Time of<br>Injury          | 28c. Injur<br>Wor  | y at                                     | 28d. Describe                           |                          |                                 | any)   |
| endin<br>sath.<br>or: Af  | atic             | 1 ■ Natural 2 □ Accident  | 5 Pending investigate                  | on   | 7 501)                  | mary                            |  | Yes 2 □No                                |   |                          |                                 |  |
| or Att  | Certification:   | 3 ☐ Suicide<br>4 ☐ Homicide   | 6 Could not determine                  |  | iry - At ho<br>(Specify | me, farm, ştre                  | eet, factory, office   |  | 28f. Location (<br>City or To           | Street and<br>wn, State) | d Number or Ru                  | ral Route Number,                                  |
| pitei   | Ce               | 29a. Certifier  | 1 Caritying 5                          | Physicians To the heat of  | 6 1                     |                                 |  |  |   |                          |                                 |  |
| To the Hospitel or Attending Is within 24 hours after death. To the Funeral Director: After completely filled in by the funer   | Medical          | (Check only one)  | 2 Medical Exa                          | Physician: To the best of aminer: On the basis of and manner sta | examinal                | wiedge, death<br>ion and/or inv | occurred at the tir<br>restigation, in my o  | ne, date and place<br>pinion, death occi | e, and due to the urred at the time.    | date and                 | and manner as<br>place, and due | stated.<br>to the cause(s)                         |
| To the within Fo the comple   | Me               | 29b. Signature and  | title of certifier                     |  |                         |                                 | 29c. Licens  |  |   |                          | e signed (Month                 |  |
| . 21-0  |                  | 1   | Jorka                                  | ran  |                         |                                 | D =  | 21649                                    |   | Dec                      | eples                           | 19 2005  |
| n   |                  | 30. Name and addr   | ress of person who                     | o completed cause of de  | ath (Item               | 23a) (Type, I                   | Print)   | - (                                      |   |                          | _,,                             |  |
| 7   | 157              | SARA  | INDAY K                                | SASKARA  | /                       | 3455                            | -WILK  | ENS A                                    | VE BAL                                  | TIN                      | W.ZE, 1                         | 19, 2005<br>MD 21223                               |
| Sta<br>Registra   |                  | 31. Date filed (Mon   | DEC 2 3                                | 32. Registra   | r's 6ignat              | ure A                           | real s   |  | •                                       |                          | ,                               |  |
|   |                  |   | WE WIN U                               |  | The state of            | - NO                            | A STATE OF THE PARTY OF THE PAR |  |   |                          |                                 |  |

|  |                   | 1 - For<br>State<br>Registrar   | State of I                        | Marylan                                     | d / Depa                    | artment<br>rtificate                    | t of H                      | ealth a<br>Death       | and Me         |                                 | jiene                        | $O \cup O$                | Production of the Control of the Con | 558                          |
|--|-------------------|---|-----------------------------------|---|-----------------------------|---|-----------------------------|------------------------|----------------|---------------------------------|------------------------------|---------------------------|--|------------------------------|
| Physic   | ion               | 1. Decedent's Name (First, Middle, Last   | )                                 |   |                             |   |                             |                        | 2              | 2. Date of Dea<br>Month         | th<br>Day                    | / Yee                     | 3. Tin   | ne of Death                  |
| Physic<br>/Med   |                   | Clifford E. South   |                                   | .,  |                             |   |                             |                        |                | Month<br>Decembe                |                              |                           |  | :15 P M                      |
| Exami  | iner              | 4a. Facility Name (If not institution, give                                     |                                   | er)   |                             |   |                             | Location o             | f Death        |                                 |                              | County of De              |  | 1 -                          |
|  | , item            | Laurel Regional I   |                                   | Age (In yrs.                                | last highdayl               | If Under                                | urel                        | If Under 2             | 24 Hrs 6       | B. Date of Birth                |                              | rince                     |  |                              |
| Funera<br>Director   |                   |   | X<br>2 M 2 □ F / .                | 80  | Yrs.                        | Months                                  | Days                        | Hours                  | Min.           | Month, Day                      | , Year)                      | (                         | Country)   | ate or Foreign               |
| 394  |                   | Usual Residence of Decedent   |                                   |   |                             | ll                                      |                             |                        |                | March 2                         | - او/-                       | 723 11                    |  |                              |
| arylan   | -                 | 10a. State 10b. County  |                                   |   | y, Town or Lo               |   | . ~                         |                        |                |                                 |                              |                           |  | le City Limits<br>Yes 2 ☑ No |
| Ne Misself   | Director          | Maryland Prince (   | seorge s                          |   | ilver                       |   |                             |                        |                |                                 | 0- 04                        | izen of What (            |  | 165 201140                   |
| with 1   | ā                 | 3154 Gracefield I   | Road, #3                          | 12  |                             | 10f. Zip                                | 904                         |                        |                | ,                               | -                            | ited S                    |  |                              |
| Jeath<br>The 23  | Funerai           | 11. Marital Status  | 12. Was Decede                    | ent Ever in U.                              | .S. 13.                     | Was Deced                               | lent of His                 | spanic Orig            | gin? (Spec     | rfy Yes or No-                  |                              | 14. Race - Ал             | erican India   | n,                           |
| after or Ital  | F                 | 1 Never Married 2 Marned  | Armed Force 1 ⊠Yes 2 If Yes, Give | □ No  |                             | lf Yes, spec<br>1 ☐ Yes 2               | •                           | n, Mexican<br>Specify: | , Puerto H     | ican, etc.)                     |                              | Black, Wh                 |  |                              |
| Jural',  | d by              | 3 Widowed 4 Divorced  | Year or Date                      | s: 1943 <b>-</b> 1                          | .946                        |   |                             |                        |                |                                 |                              | Specify: W                |  |                              |
| n 72 h   | Completed         | 15. Decedent's Edu<br>(Specify only highest grad                                | de completed)                     |   | (Give                       | dent's Usua<br>kind of wor<br>DO NOT us | k done d                    | urina most             | of working     | 9                               |                              | ind of Busines<br>.ted St | ,  |                              |
| withi<br>iene.<br>then   | dmo               | Elementary/Secondary (0-12)   | College (1-4<br>5+                | or 5+)                                      |                             | gn Se                                   | ,                           |                        | ficer          |                                 |                              | ormati                    |  | ency                         |
| Hyg<br>other   | BeC               | 17. Father's Name (First, Middle, Last)   |                                   |   |                             |   |                             |                        |                | First, Middle,                  |                              |                           |  |                              |
| uld be<br>Menta<br>Menta<br>irked  | To B              | Charles Wesley So   | ıthard                            |   |                             |   |                             | Jes                    | sse A          | va Mont                         | gom                          | ery                       |  |                              |
| permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Heatth and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23e or 28e-f show sny injury or other treumatic event, the Modical Examinar must be notified at once.  |                   | 19a. Informant's Name/Relationship (T)  |                                   |   |                             | •                                       |                             |                        |                | Route Number<br>Silver          |                              |                           |  | 1 2000/                      |
| C, R   |                   | Anne W. Southard/V  | vile                              | 20b. F                                      | Place of Dispo              |   |                             | Koad                   | Tr 312,        |                                 |                              | cation - City o           |  |                              |
| nt of h  |                   | 1 ☐ Burial 2 ☑ Cremation 3 ☐ I  |                                   | ate C                                       | emetery, crei               | matory or of                            | ther place                  | ַ עו                   | ecemb          | er 22,                          |                              | hesda,                    |  |                              |
| rail. Pages pertinent of portant: If It or y injury or   |                   | 4 Donation 5 Other (Specify, 21. Signature of Funeral Service Licens            |                                   | 7   | itgome:                     |   |                             |                        | 200.<br>y Robe |                                 |                              | -                         | -  |                              |
| Depermine Depermine Important Important Incorporation Series once.   |                   | Leo.  | 0                                 | _ мо1                                       | 433 Be                      | thesd                                   | la-Ch<br>la. M              | evy (                  | Chase          | rt A.<br>Inc.<br>0814-35        | 755<br>501                   | 7 Wisc                    | onsin  | Avenue                       |
|  |                   | 23a. Part1. Enter the disease, or comp<br>shock, or heart failure. List only of | lications that cau                | sed the deat                                |                             |   |                             |                        |                |                                 |                              |                           |  | Between                      |
| Physician  |                   | Immediate Cause (Final disease or condition                                     |                                   |   | Arrhy                       | thmia                                   | l.                          |                        |                |                                 |                              |                           | Onset  | and Death                    |
| /Medical<br>Examiner   |                   | resulting in death)   |                                   | as a conseq                                 |                             |   |                             |                        |                |                                 |                              |                           |  |                              |
| Examine  |                   | Sequentially list conditions, if any, leading to immediate                      | n                                 | ary Ar                                      | tery I                      | iseas                                   | e                           |                        |                |                                 |                              |                           | 1  |                              |
| d being the property of the pr | Examiner          | cause. Enter Underlying<br>Cause (Disease or injury                             | 200 10 (0.                        | 404 0011004                                 | 301.00 3.7.                 |   |                             |                        |                |                                 |                              |                           |  |                              |
| be executed ician and burial-transit   | Exa               | that initiated events<br>resulting in death) Last                               | Due to (or                        | as a conseq                                 | uence of):                  |   |                             |                        |                |                                 |                              |                           |  |                              |
| cate be executed physician and the burial-transit  | Physician/Medical | (   | d                                 |   |                             |   |                             |                        |                |                                 |                              |                           |  |                              |
| The law requires that the death certificate are been signed by the attending physege 2 should be detached for use as the   | Med               | IF FEMALE:  | 22- 11                            |   |                             |   |                             |                        |                |                                 |                              |                           |  |                              |
| wrequires that the death certific been signed by the attending p should be detached for use as it.   | ian               | in the past 12 months?  |                                   | me of pregna<br>1 2 □ Feta<br>tat time of d | Ideath 3                    | Ectopic pro                             |                             |                        |                |                                 | 2                            | 23d. Date of d<br>Month   | elivery<br>Day   | Year                         |
| the dy the dy the  | nysic             | 1 Yes 2 No<br>9 Unknown   | 9☐ Unknow                         |   |                             | 2 Othor (3p                             | 5011y/                      |                        |                |                                 |                              |                           |  |                              |
| s that   | by Pt             | Part II. Dther significant conditions co  |                                   |   |                             |   |                             |                        |                | 23e. Did tol                    | bacco u                      | se contribute             | to the cause   | of death?                    |
| w requires to been signal should be  | ed b              | Congestive Heart  | Failure                           | , Chro                                      | nic Ob                      | struc                                   | tive                        |                        |                | 1 🗆 Ye                          | es 2[                        | □No 3□F                   | Probably 4   | ⊠Unknown                     |
| taw re<br>as be  | Completed         | Pulmonary Disease   | e                                 |   |                             |   |                             |                        |                | 24a. Was a                      | SV.                          | 24b. Were a               | utopsy findi   | ngs available<br>of cause of |
| The<br>The   | Con               |   |                                   |   |                             |   |                             |                        |                | perform                         | ned?<br>2 <mark></mark> € No | death?                    | s 2 No   |                              |
| VILCIAN:<br>Sertific<br>ector,   | Be                | 25. Was case referred to medical examiner?                                      | Hospital:                         |   |                             |   | Otho                        |                        |                | Check only on                   |                              |                           |  |                              |
| Phys<br>this   | 1                 | 1 ☐ Yes 2 ☑ No 27. Manner of Death  | 1 ☐ Inp                           |   | ER/Outpatier<br>28b. Time o |   |                             | 4 🗆 140                |                | e 5 Reside                      |                              |                           | ecify)   |                              |
| th.<br>After   | tlon:             | 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation                              | (Month,                           | Day Year)                                   | Injury                      | м                                       | 8c. Injury<br>Work<br>1 🗌 Y | ?<br>′es 2 □ !         |                | 76. 2000/100 TH                 | 344 III JUI                  | y 000u110u                |  |                              |
| Atter<br>or dea<br>ector<br>by the   | Certificat        | 3 Suicide 6 Could not be 4 Homicide determined                                  | 289. Place of                     | Injury - At he<br>, etc. (Specif            | ome, farm, sti              | reet, factory                           | , office                    |                        | 28             | If Location (St<br>City or Town | treet and                    | d Number or F             | Rural Route  | Number,                      |
| s after or selection of selection or selecti | Cert              | Tomoso  | ballaling                         | , etc. (Specif                              | y/<br>                      |   |                             |                        |                | Only or 10W                     | ı, otato,                    |                           |  |                              |
| To the Hospital or Attending Physician: The lav within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2:  | edicai            | 29a. Certifier 1 Certifying Phy<br>(Check only 2 Medical Exam                   | iner: On the basi                 | s of examina                                | wledge, deat                | h occurred vestigation,                 | at the tim<br>in my op      | e, date and            | d place, an    | nd due to the ca                | ause(s)<br>ate and           | and manner a              | is stated.   | se(s)                        |
| thin 2<br>the 1<br>mplet   | Med               | 29b. Signature and (ittle) of certifier   | and manne                         | r stated.                                   |                             |   | License                     |                        |                |                                 |                              | e signed (Mor             |  |                              |
| ¥.¥5 8   |                   | 1 1 1   | 1                                 |   |                             | Ì                                       | 2403                        |                        |                |                                 |                              | mber 1                    | -  |                              |
| 001-1  |                   | 30. Name and address of person who o  | completed cause                   | of death (Iten                              | n 23a) (Type,               | Print)                                  |                             |                        |                |                                 |                              |                           |  |                              |
| ZUTI   |                   | Eugenio Machado,  |                                   |   |                             |   | l, Si                       | lver                   | Spri           | ng, Mar                         | yla                          | nd 209                    | 04   |                              |
| S<br>Regis   | tate              | 31. Date filed (Month, Day, Year)   | 32 Reg                            | istrar's Signa                              | iture                       |   |                             |                        |                |                                 |                              |                           |  |                              |

|                     |  |                     | 1 - For<br>State<br>Registrar  | State of Marylar  |                       | rtment of I   |  |  | ene<br>2005                         | 41559                                     |
|---------------------|--|---------------------|--|---|-----------------------|---|--|--|-------------------------------------|---|
|                     | Physici<br>/Medic<br>Examir  | cal                 | Decedent's Name (First, Middle, Last)  4a. Facility Name (If not institution, give str   | A1 1 /  | ah                    | 5 ha 4b. City, Town, o                                    | or Location of Dea                       | 2. Date of Death<br>Month<br>Decemb                              | Day Year                            | 3. Time of Death 10:00 AM                 |
| ile)                | Funeral<br>Director  |                     | 5. Social Security Number 6. Sex 286-12-9978   | 7. Age (In)yrs.   | last birthday) Yrs.   | If Under 1 Year<br>Months Days                            | If Under 24 Hr.<br>Hours Min             | s. 8. Date of Birth  | rear) Co                            | thplace (State or Foreign<br>unitry)<br>O |
|                     | filed within 72 hours after death with the Maryland<br>Hygiene.<br>other than "netural", or items 23a or 28a-f show<br>ent, the Medical Examiner must be notified at   | Funeral Director    | MD 10a. State 10b. County MD 10e. Street and Number  |   | ty, Town or Loc       | ore   | 0.7                                      | 100  | g. Citizen of What Co               | 10d. Inside City Limits 1                 |
| 036                 | permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mantal Hygiene. Important: If item 27 is marked other than "natural, or items 23a or 28a-f show any injury or other traumatic event, the Madical Examiner must be routilised at Once.   | þ                   | 3320 Benson Avenue  11. Marital Status  1  Never Married 2 Married  3 XWidowed 4 Divorced  | Was Decedent Ever in U<br>Armed Forces?<br>1 _ Yes _ 2  No<br>If Yes, Give  Year or Dates:  | If                    | 212 /as Decedent of H Yes, specify Cub                    |  | Specify Yes or No-<br>rto Rican, etc.)                           | USA  14. Race - Ame Black, Whit     |   |
| Maryland 21215-0036 | ed within 72 hoi<br>rgiene.<br>ser then "netura<br>t, the Modical E  | Completed           | 15. Decedent's Educa<br>(Specify only highest grade of<br>Elementary/Secondary (0-12)  | cion<br>completed)<br>College (1-4or 5+)  | (Give k<br>life. D    | ent's Usual Occup<br>ind of work done<br>O NOT use retire | during most of wo<br>d)                  | orking 16  | 6b. Kind of Business                | Industry unk                              |
| laryland            | 2 should be fill and Mentat Hy Is marked oth sumatic sven  | To Be               | 17. Father's Name (First, Middle, Last)  Peter Woodward Sr  19a. Informant's Name/Relationship (Type   |   |                       |   | Bertha<br>and Number or R                | me (First, Middle, Ma<br>Chloe Bar<br>ural Route Number, (       | tlett<br>Dity or Town, State, 2     | Zip Code)                                 |
| Baltimore, N        | Pages 1 and<br>ment of Health<br>lant: If item 27<br>jury or other tr  |                     | St. Elizabeth Nurs  20a. Method of Disposition  1 Burial 2 Cremation 3 Ren 4 XDonation 5 Other (Specify)   | 20b. F  | Place of Dispos       | and the second second second second                       |  | altimore,  | MD 21227<br>lc. Location - City or  | Town, State                               |
| Ba                  | Departition in the control of the co |                     | 21. Signed use of Funeral Strivice Licenses Ronald S Western Land 1 S West | tions that caused the deat  | r St                  |   | omy Boar                                 | d 655 W. ]   |                                     | Street Approximate Interval Between       |
| Z.,                 | Physician /Medical Examiner putual-fransit   | Examiner            | Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  | Due to (or as a conseq  | uence of):            | mell  | y dis                                    | edse   |                                     | Onset and Death V-P (W )                  |
| O. Box 68/60,       | sath certificate<br>attending phy<br>for use as the  | Physician/Medical E | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 2 No 9 □ Unknown  | Due to (or as a consequence of pregnation of pregnation of the consequence of pregnation of the consequence of pregnation of the consequence of t | uncy<br>I death 3⊟E   | ectopic pregnancy<br>Other (specify)                      | ,  |  | 23d. Date of deli                   | very<br>Day Year                          |
| <b>3</b> .          | w requires that the de<br>s been signed by the<br>should be detached   | Completed by Phy    | Par II. Other significant conditions contri<br>Chronic ven<br>Dementa  | 1 / . /   | ulting in the und     | derlying cause giv  | en in Part I.                            |  | cco use contribute to               | 1   |
| r Vital Records,    | The<br>ate h<br>page   | To Be Com           | 25. Was case referred to medical examiner?   | pital: 1 ☐ Inpatient 2 ☐  | ER/Outpatient         | 3□ DOA Cth  |  | autopsy performe  1 Yes 2  ath Check only one)  Home 5 Residence | d? prior to death? No 1 □ Yes       | ompletion of cause of                     |
| DIVISION OF         | r Attending Physician:<br>er death.<br>rector: Atter this certific<br>by the funeral director.   | Certification:      | 2 Accident investigation   | 28a. Date of Injury<br>(Month, Day Year)<br>28e. Place of Injury - At ho<br>building, etc. (Specifi   | 28b. Time of Injury   |   |  | 28d. Describe how  | injury occurred of and Number or Ru |   |
| ם                   | To the Hospital or Attending Pr<br>within 24 hours alter death.<br>To the Funeral Director: After th<br>completely tilled in by the funeral  | edicai              | one)   | an: To the best of my kno<br>: On the basis of examinal<br>and manner stated.   | wledge death o        | occurred at the tin<br>stigation, in my o                 | ne, date and place<br>pinion, death occu | and due to the cause   | and manner an                       | stated.<br>to the cause(s)                |
| •                   | To Y   | ×                   | 29b. Signature and title of certifiar.  30. Name and address of person who comp  | ) M   | 1)<br>123a) (Type, Pr | 29c. Licens   |  |  | Date signed (Month                  | Day, Year)<br>19,2003<br>21227            |
|                     | Sta<br>Registr   | te                  | Ming V, 3520 B<br>31. Date filed (Nonth, Day, Year)<br>DEC 2 3 2005  | emson / V-<br>32 Registrar's Signal   | enve                  | , Isal  | timore                                   | , Mary   | and 2                               | 2122/                                     |

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 2. Date of Death 3 Time of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 2005 24 5:00 a Pamula L. Simms November /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b City Town or Location of Death 7. Age (In yrs. last birthday) | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | June 15 19 Examiner Prince George's 12209 Sturdee Drive 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** 1□M 2√□F 1942 Maryland Director 215-40-8707 Usual Residence of Decedent the Maryland 10b. County 10c. City. Town or Location 10d. Inside City Limits 10a. State 28e-f ehow the Medical Examiner must be notified at to Yes 2 □ No Maryland Prince George's Upper Marlboro Direct 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 23a or 20772 12209 Sturdee Drive USA death 1 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. within 72 hours after 1 Never Married 2 Married Black Baltimore, Maryland 21215-0036 0 1 ☐ Yes 2 No Specify: ģ 3 Widowed 4 Divorced neturai Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Executive Office of College (1-4or 5+) Elementary/Secondary (0-12) Lyst the President of the United States

18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be filed win Department of Health and Mental Hygient important: if item 27 is merked other the any injury or other treumatic event, If an one. Budget Analyst 12th 2 yrs. 17. Father's Name (First, Middle, Last) Be Alphonse Simms Sarah Henderson ၉ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John E. Simms Jr. (Husband) 12209 Sturdee Dr. Upper Marlboro, Md. 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition cometery, crematory or other place)
Maryland Veteran
Cemetery 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 12/1/05 Crownsville, Md. 22. Name and Address of Facility Wm. Reese & Sons Mortuary, 21. Signature of Funeral Service Licensee Jarry H, Rease Mcc 483

821 West St. Annapolis,
23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. West St. Annapolis, Md. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) OVAKIAN **Physician** a Metastatic months /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed burial-transit end Due to (or as a consequence of): Box 68760. ettending physician Completed by Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ed by the etter in the past 12 months?
1 Yes 2 No Month Day 4☐Pregnant at time of death 5 ☐ Other (specify) Division of Vital Records, P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No hes certificate 1 Yes 2 → No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Certification: To Be Home Hospice Other: 4 Nursing Home 5 Assidence 6 Other (Specify) Hospital: 1 Yes 2 No 1 | Inpatient 2 | ENOutpatient 3 | DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 DNatural 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours aft To the Funeral Di completely filled in To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medicai 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number CA II FORNI A 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 12/01/2005 A53196 - 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6900 Georgin Ave, Dept of GYN ONCOLOGY, NW Wash DC 20307 Dr. G. Scott Rose . Registrar's Signature

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

DEC 2 3 2005

DHMH 17 Rev 1/2001

Registrar

DEC 23

|              |   |                | 1 - For<br>State<br>Registrar   | State of M   | aryland / Depa<br><i>Ce</i>                               | artment of H                              |   |   | iene<br>005                                  | 41562  |
|--------------|---|----------------|---|--|---|---|---|---|--|--|
| т ж          | *   |                | Decedent's Name (First, Middle, Last  | st)  |   |   |   | 2. Date of Deat                             | -  | 3. Time of Death                                   |
| 23           | Physici<br>/Medic   |                | Rosiebell Somme   |  |   |   |   | Decemb                                      |  |  |
|              | Examir  | er             | 4a. Facility Name (If not institution, given Knollwood Mano)  |  |   |   | r Location of Death<br>rsville            | 1   | 4c. County of De                             |  |
|              | Funeral   |                | 5. Social Security Number 6. S 212-42-1736  | ex 7. Ag   | e (In yrs. last birthday)<br>64 Yrs.                      | If Under 1 Year<br>Months Days            | If Under 24 Hrs.<br>Hours Min.            | (Month, Day,                                | Year) 9. B                                   | inthplace (State or Foreign Country)               |
| the state of | Director  |                | Usuat Residence of Decedent   | **   | 0-1 113.  |   |   | Feb 14                                      | 1941 Ma                                      | ryland   |
|              | anylan  | - P            | 10a. State 10b. County  | cun do 1   | 10c. City, Town or Lo                                     | _   |   |   |  | 10d. Inside City Limits                            |
|              | the Ma  | ecto           | 100 Street and Number   | under  | Gren  | Burnie                                    |   |   | 0g. Citizen of Whaf (                        | 1 Yes 2XX0   |
|              | 3a or   | Di             | 301 Juneberry V   | Way Apt.   | 1B  | 2106                                      | 1   | '   | USA  | Journay ?  |
|              | deetil  | ner            | 11. Marital Status  | 12. Was Decedent<br>Armed Forces?                              | Ever in U.S. 13.  | Was Decedent of h                         | lispanic Origin? (S<br>an, Mexican, Puert | pecify Yes or No-                           | 14. Race - Ал                                |  |
| 920          | s 1 and 2 should be filed within 72 hours after deeth with the Maryland of Health and Mental Hygiene. Item 27 is marked other then "nature!, or iteme 23s or 28s-f show other traumatic event, the Madical Examiner must be notified at | by Fu          | Maryland Anne Anne Anne Anne Anne Anne Anne An  | 1 ☐ Yes 2 X<br>If Yes, Give<br>Year or Dates:                  | No  | 1 ☐ Yes 2 🛣No                             |   | o rican, etc.)                              | Specify: B                                   | •  |
| 215-0036     | 72 ho<br>natur  | eted           | 15. Decedent's Ec<br>(Specify only highest gra  | ducation   | 16a. Dece   | dent's Usual Occup                        | pation<br>during most of wor<br>d)        | king  | 16b. Kind of Busines                         | s/Industry   |
| 2121         | filed within Hygiene.   | Completed      | Elementary/Secondary (0-12)<br>9th  | College (1-4or   | 5+)   | DO NOT use retire:<br>usewife             | d)  |   | None   |  |
|              | al Hyg  | BeC            | 17. Father's Name (First, Middle, Last)   |  |   |   | 18. Mother's Nan                          | ne (First, Middle, M                        | Maiden Sumame)                               |  |
| Maryland     | nould be<br>d Mental<br>narked o<br>natic eve   | <sup>C</sup>   | Elijah Sommervi   |  | 401 14 11   |   |   | rances l                                    |  |  |
| M            | od 2 sho<br>lith and<br>27 is mu  |                | 19a. Informant's Name/Relationship ( Louise Scott(Ni  |  |   |   |   |   | City or Town, State,                         |  |
| Je,          | of Heal   |                | 20a. Method of Disposition  |  | 20b. Place of Dispo                                       |   |   |   | 20c. Location - City of                      |  |
| Baltimore    | Page<br>ment c  |                | 1 Buriaf 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specification)   |  | Carpent   | er Hill                                   | 12-                                       |   |  | Park, Md.  |
| Ball         | permit. Pages 1 and 2 sh<br>Department of Health and<br>important: if item 27 is m<br>any injury or other traum<br>once.  |                | 21. Signature of Funeral Service Licer  | 1  | 6 483 8   | Name and Addre<br>M. Rees<br>21 West      | e & Son<br>St. An                         | s Mortu<br>napolis                          | ary, P.A<br>, Md. 21                         | 401  |
|              |   |                | 23a. Part1. Enter the disease, or com<br>shock, or heart failure. List only                                 | plications that caused<br>one cause on each li                 | the death. Do not entine.                                 | er the mode of dyir                       | ng, such as cardiac                       | or respiratory arre                         | est,   | Approximate<br>Interval Between<br>Onset and Death |
| Ė,           | Physician<br>/Medical   |                | fmmediate Cause (Final disease or condition resulting in deafh)   | a CH   | RONIC   | RENAL                                     | - FAI                                     | LURE  |  | YEARS  |
|              | Examiner  |                |   | Due to (or as  | a consequence of):  |   |   |   |  |  |
|              | P #   | iner           | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | Due to (or as  | a consequence of):  |   |   |   |  |  |
|              | and and al-trans  | Examiner       | that initiated events resulting in death) Last  | c<br>Due to (or as   | a consequence of):  |   |   |   |  |  |
| 58760,       | cate be executed<br>physician and<br>the burial-transit   | dicai E        |   | d  | ,   |   |   |   |  |  |
| _            | rtificat<br>ng phy<br>as th   | Medi           | fF FEMALE:  |  |   |   |   |   |  |  |
| Вох          | death certific<br>attending p   | Physician/Me   | 23b. Was decedent pregnant in the past 12 months?   |  | 2 Fetaf death 3   | Ectopic pregnancy                         | /   |   | 23d. Date of d                               | elivery<br>Day Year                                |
| P.O.         | the de  | nysic          | 1 □Yes 2 No<br>9 □ Unknown  | 4□Pregnant at<br>9□Unknown                                     | time or death 5L  | Other (specify) _                         |   |   |  |  |
|              | ires that the death<br>signed by the alter<br>I be detached for u   | by P           | Part ff. Other significant conditions of  |  | uf not resulting in the u                                 | nderlying cause giv                       | ven in Part I.                            | 23e. Did tob                                |  | fo the cause of death?                             |
| ord          | w require<br>been si<br>should I  | sted           | HYPERTE   | N3/0N  |   |   |   | 1 🗆 Ye                                      | s 2 □ No 3 □ F                               | Probably 4 Unknown                                 |
| Records,     | The law requires that the death certif<br>ate has been signed by the attending<br>page 2 should be detached for use a   | Completed      |   |  |   |   |   | 24a. Was autops perform                     | y prior to                                   | autopsy findings available completion of cause of  |
| Vital        | an: T<br>tificate<br>tor, pa  | 0              | 25. Was case referred to medical  |  |   |   | 26 Place of Dea                           | 1 ☐ Yes 2<br>th (Check only on              | No 1□Ye                                      | s 2 No   |
| Ž            | Physician:<br>this certific<br>ral director,  | To B           | examiner?<br>1 ☐ Yes 2 1 No   | Hospital:  | ent 2 ER/Outpatier  | nt 3□DOA Oth                              | 05 4                                      |   | nce 6 ☐Other (Sp                             | ecify)   |
| n of         |   |                | 27. Manner of Death 1 Naturaf 5 □ Pending   | 28a. Date of Inju<br>(Month, Da                                | y Year) 28b. Time o                                       | Wor                                       | y af<br>k?                                | 28d. Describe ho                            |  |  |
| Division     | Attending r death. ector: After by the fune   | licati         | 2 Accident investigation 3 Suicide 6 Could not be   |  | ury - At home, farm, str                                  |   | Yes 2 □No                                 | 28f Location (St                            | reet and Number or F                         | Pural Route Number                                 |
| 2            | tal or A<br>rs after<br>ai Dire<br>ed in by   | Certification: | 4 Homicide determined   | building, et   | c. (Specify)  | eet, ractory, onice                       |   | City or Town                                |  | iora: Fronte Number,                               |
|              | To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the  | Medical        | 29a. Certifier 15 Certifying Ph<br>(Check only one) 2 Medical Exen  | ysician: To the best<br>niner: On the basis o<br>and manner st | of my knowledge, deat<br>f examination and/or in<br>ated. | h occurred at the tirvestigation, in my o | me, date and place<br>pinion, death occu  | , and due to the ca<br>rred at the time, da | use(s) and manner a<br>ate and place, and du | is stated.<br>e to the cause(s)                    |
|              | To th<br>within<br>To th<br>compl   | Me             | 29b. Signature and the of certifier   | 1 12   |   | 29c. Licens                               |   |   | 9d. Date signed (Mor                         |  |
|              | ~   |                | 1 Brilin  | Illa   | ~ nw  | DE  | 31136                                     | Z   | ECEMBE                                       | P21,2005   |
|              | 9   |                | 30. Name and address of person who  | completed cause of c   | leath (Item 23a) (Type,                                   | Print)                                    | 210.5 1                                   | A LL  | The short                                    | 100  |
| 280          | Sta   | te.            | 31. Date filed (Month, Day, Year)   | CACE IVI<br>32. Redistr  | ar's Signature  | KILIBA                                    | CIUCK                                     | U, DAZ                                      | I MORE                                       | m) 2/236   |
|              | Registr   |                | DEC 2 3 3   | 2005   | 20 1  | 2   |   |   |  |  |

DHMH 17 Rev 1/2001

ORIGINAL

|             |   |                | 1 - For<br>State<br>Registrar  | State of Ma   | ryland              |                        | rtment of H<br>tificate of L                                    |  |  | giene 0 5          | 5 415  | 63                   |
|-------------|---|----------------|--|---|---------------------|------------------------|---|--|--|--------------------|--|----------------------|
|             | Physici<br>/Medic   |                | 1. Decedent's Name (First, Middle, Las<br>Eddie Taylor   | t)  |                     |                        |   |  | 2. Date of Dea<br>Month                  |                    | 3. Time<br>25 //                             | of Death             |
|             | Examin  |                | 49 Facility Name (If not institution give Peningula Ugjon) N   | street and number)  | 21                  |                        | 4b. City, Town, or<br>Sali 8                                    | Mury                                     |  | 4c. County of      | Death  |                      |
|             | Funeral<br>Director   | 0,             | 420-90-4244  | 9x 7. Age   | (In yrs. Ia.<br>_55 | st birthday) _<br>Yrs. | Months Days   | If Under 24 H<br>Hours Mi                |  | (, Year)           | 9. Birthplace (State<br>Country)             | e or Foreign<br>unk  |
|             | Maryland<br>f ahow  | or             | Usual Residence of Decedent  10a. State  10b. County   |   |                     | Town or Loc            |   |  |  |                    | 10d. Inside                                  | City Limits          |
|             | with the harder or 28s-   | Director       | MD Wicon   |   |                     | Salish                 | 10f. Zip Code   | 100/                                     |  | 10g. Citizen of Wh | nat Country?                                 |                      |
| 36          | within 72 hours after deeth with the Maryland<br>ene.<br>than "natural", or Items 23a or 28a-f ahow<br>I.a McJical Examinar must be modified at | by Funeral     | 757 S. Division  11. Marital Status  1 Never Married 2 Married   | 12. Was Decedent E<br>Armed Forces?<br>1 ☐ Yes 2 1 No<br>ff Yes, Give           |                     | lf .                   | 1   | 1804<br>spanic Origin?<br>n, Mexican, Pu | (Specify Yes or No-<br>erto Rican, etc.) | Black,             | - American Indian,<br>White, etc.<br>black   |                      |
| 1215-0036   | d within 72 hours<br>jene.<br>Ir than "natural",<br>Ir than "natural",  | Completed b    | 3 Widowed 4 Divorced  15. Decedent's Ed (Specify only highest gra-   | Year or Dates:<br>lucation<br>de completed)<br>College (1-4or 5+                | )                   | 16a. Deced             | ent's Usual Occupa<br>kind of work done d<br>O NOT use retired, | uring most of w                          | unk                                      | 16b. Kind of Busi  |  | unk                  |
| Maryland 21 | be filed<br>tel Hygi<br>d other<br>avant, I   | To Be Cor      | unk unk 17. Father's Name (First, Middle, Last)  | ınk   |                     |                        | unk   | 18. Mother's N                           | lame (First, Middle,                     | Maiden Sumame,     | )  | unk                  |
|             | s 1 and 2 should if Health and Men<br>if em 27 is marke<br>other traumatic  | _              | 19a. Informant's Name/Relationship (7  |   |                     | 100 I                  | E. Carrol   |  | Rural Route Numbe                        |                    |  |                      |
| altımore,   | permit. Pages 1 Department of H Important: If ites any injury or ott  |                | 20a. Method of Disposition  1 Burial 2 Cremation 3 4 Donation 5 Other (Specify  21. Signature of Funeral Service Licen | ) in state  | 20b. Pla            | metery, crem           | ition (Name of<br>atory or other place                          |  | Date                                     | 20c. Location - C  | ity or Town, State                           |                      |
| Ва          | Depa<br>Impo<br>any b   |                | Ronald S.  23a. Palt1. Enter the disease or comp   | Wade Dire   |                     | St<br>Ba               | ltimore,  | omy Boar<br>MD 21:                       |  |                    |  |                      |
|             | Physician<br>/Medical   |                | shock, or heart failure. List only of fmmediate Cause (Final disease or condition resulting in death)                  | a. Due to (or as a  | Para                | liac                   |   | y H.m.                                   |  | (951,              | Approxim<br>fnterval B<br>Onset an           | letween              |
| þ           | Examiner  | ner            | Sequentially list conditions, if any, feading to immediate cause. Enter Underlying                                     | b. Due to (or as a  | Hy                  | ne En                  | sra /   | ,  |  |                    | 1  | be.                  |
| 38/60,      | icate be executed<br>physicien and<br>s the burial-transit  | dical Examiner | Cause (Disease or injury that initiated events resulting in death) Last  | cDue to (or as a  | conseque            | thigh of):             | zoloni  | <u>.</u>                                 |  |                    | 29   | Chès.                |
| O. Box 6    | death certiff<br>e attending<br>id for use as   | Physician/Mec  | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown                                | 23c. ff yes, outcome o<br>1 ☐ Live birth 2<br>4 ☐ Pregnant at ti<br>9 ☐ Unknown | Fetal d             | death 3 🗌              | Ectopic pregnancy<br>Other (specify)                            | NA                                       |  | 23d. Date<br>Monti | ,  | Year                 |
| rds, r      | requires that the dei<br>neen signed by the a<br>hould be deteched fi   | þ              | Part If, Other significant conditions of   | ontributing to death but  | not result          | ting in the un         | derlying cause give   | n in Part I.                             |  |                    | ute to the cause o                           | _                    |
| II Kecords, | The law<br>ate has b<br>page 2 s  | Completed      | - Cancu  | in Ro   | Kig                 | ry Fa                  | Z.  |  | 24a. Was a autop perfor 1 Tyes           | sy pri             | ere autopsy finding or to completion of ath? | s available cause of |
| or Vital    | Physician:<br>this certifica<br>al director, i  | To Be          | 25. Was case referred to medical examiner? 1 Yes 2 No  | Hospital:   | 2 🗆 E               | R/Outpatient           | 3 □ DOA Othe  |  | Death (Check only or<br>Home 5 ☐ Resid   |                    | (Specify)                                    |                      |
| DIVISION    | al or Attending Physician:<br>s after death.<br>I Director: After this certific<br>d in by the funeral director,                                | Certification: | 27. Manner of Death  1 Statural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be                            |   | Year)               | 28b. Time of Injury    |   | at<br>?<br>′es 2 □ No                    |  | ow injury occurred |  |                      |
| 2           | spital or<br>ours afte<br>neral Dir<br>filled in  |                | 4 Homicide determined  29a. Certifier 1 Certifying Ph  | building, etc.  | (Specify)           | ledge, death           | occurred at the tim   | e, date and pla                          | City or Tow                              | n, State)          | or Rural Route Nu                            |                      |
|             | To the Hos<br>within 24 h<br>To the Fur<br>completely   | Medical        | (Check only 2 Medical Examone)  29b. Signature and title of certifier  | niner: On the basis of e<br>and manner state                                    | examinatio          | on and/or inv          | estigation, in my op<br>29c. License                            | inion, death oc                          | curred at the time, o                    | late and place, an | d due to the cause                           |                      |
| )           |   |                | 30. Name and address of person who   |   | ath (Item 2         |                        |   | 200                                      |  | 12/                | 6/05   | 01                   |
| 100         | Sta   | ite            | BENITO S 31. Date filed (Month, Day, Year)   | 32 Registrar  | W)                  | 134                    | O Sen   | *(D)                                     | 1213en S                                 | f. Six             | 30/ 14                                       | DZIE                 |
|             | Registr   |                | DE0 0 0 00   | or A.   | A.                  | Sin                    | all B   |  |  |                    |  | X                    |

|  |  | •                   | State of Maryland / Department of Health and N  1- State of Maryland / Department of Health and N  Certificate of Death  |  | giene<br>leg. No. 005                     | 41564   |
|--|--|---------------------|--|--|---|---|
|  |  |                     | Decedent's Name (First, Middle, Last)  | 2. Date of Dea<br>Month                | ıth                                       | 3. Time of Death  |
|  | hysicia<br>/Medica                             |                     | Catherine A. Trueheart   | Dec                                    | 17 20                                     | 730 PM  |
| 125  | xamine   |                     | 4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death   | 1                                      | 4c. County of E                           | eath  |
| ****   |  | 1                   | Beldir Healthy Rehab Center Bel Air  |  | Itart                                     | ord   |
|  | ineral   |                     | 5. Social Security Number 6. Sex 1 M 2 F 85 Yrs. Second Security Number 214-14-8548 1 M 2 F 85 Yrs. Second Security Number 1 Second Security Number 1 Second Security Number 2 Min. Second Security Number 1 Second Security Number 2 Min. Second Second Security Number 2 Min. Second | 8. Date of Birth<br>(Month, Day        | (, Year) 9.                               | Birthplace (State or Foreign Country)                         |
| - · · · · · · · · · · · · · · · · · · ·  | ector  |                     | Usual Residence of Decedent  | April 8                                | , 1920 P                                  | laryland  |
| yland  | Mor.   |                     | 10a. State 10b. County 10c. City, Town or Location   |  |   | 10d. Inside City Limits                                       |
| Mar  | B-la   | ctor                | Md. Harford Bel Air  |  |   | 1 ☐ Yes 2X No   |
| th<br>th   | or 28  | Olre                | 10e. Street and Number 10f. Zip Code   |  | 10g. Citizen of Wha                       | Country?  |
| ta<br>w  | 1 23a  | La                  | 111 S. Lynbrook Road 21014   |  | U.S.A.                                    |   |
| er de  | item<br>ingr                                   | by Funeral Director | 11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  13. Was Decedent of Hispanic Origin? (Significant Control of the Control of Hispanic Origin?)  14. Was Decedent Ever in U.S. Armed Forces?  15. Was Decedent of Hispanic Origin? (Significant Control of Hispanic Origin?)  | pecify Yes or No-<br>o Rican, etc.)    | 14. Race - A<br>Black, V                  | American Indian,<br>Vhite, etc.                               |
| )36<br>rs aft  | ro.  | by F                | 1 Never Married 2 Married 1 Yes 2 No If Yes, Give 1 Yes 2 No Specify: Year or Dates:   |  | Specify: V                                | hite  |
| <b>21215-0036</b> bd within 72 hours alf   | CalE   | ted                 | 15. Decedent's Education 16a. Decedent's Usual Occupation  |  | 16b. Kind of Busine                       | ess/Industry  |
| 215<br>Prin 7  | Med  | ple                 | (Specify only highest grade completed)  (Give kind of work done during most of work life. DO NOT use retired)  Elementary/Secondary (0-12)  College (1-4or 5+)   | rking                                  |   |   |
| 2 Ped will will be a willi | 든필   | Be Completed        | 1 office manager   |  | real esta                                 | ite   |
| laryland 21215-0036<br>2 should be filed within 72 hours after death with the Maryland<br>and Mental Hygiene.  | even<br>even                                   | Be                  |  |  | Maiden Sumame)                            |   |
| y langer   | narke  | ၉                   | Charles A. Mays Anna   | Lemcke                                 |   |   |
| ore, Maryland 21215-0036<br>is 1 and 2 should be filed within 72 hours after death with the Marylan<br>of Health and Mental Hygiene.   | 7 ie n<br>traun                                | 1                   | 19a. Informant's Name/Relationship (Type, Print)  Carolyn Trueheart Krebs/daughter 111 S. Lynbrook Road  |  |   |   |
| G - and Heali  | tem 2  |                     | 20a. Method of Disposition  1  |  | 20c. Location - City                      |   |
| MOF<br>Pages   | y or o   | - 3                 | 1 ☑Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)  Trinity Lutheran Ch. Cem.   |  |   |   |
| Baltimore,<br>Permit. Pages 1 at<br>Department of Hea  | important: if ite<br>any injury or of<br>once. |                     | 21. Signature of Fineral Service Limitee  22. Name and Address of Facility Schimunek Funeral   |  |   |   |
| Ö Pag  | 토흑립  |                     | 20121 1 12 0 2   |  |   |   |
|  |  |                     | 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line.   | or respiratory ari                     | rest,                                     | Approximate<br>Interval Between                               |
| Phys   | sician   |                     | Immediate Cause (Final disease or condition  | aret 11                                | ).  | Ontet and Death   |
|  | edical   |                     | resulting in death)  Due to (or as a consequence of):  |  | ~ /                                       |   |
| = <b>X</b> (2)   | miner  | _                   | Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):  |  |   |   |
| Ø 1/8  | ısıt   | Examiner            | if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury   |  |   |   |
| X xecut  | sicien and<br>burial-transit                   | xan                 | that initiated events c. resulting in death) Last Due to (or as a consequence of):   |  |   |   |
| 760, C   | bur  | calE                |  |  |   |   |
| 68 F   |  |                     | V.   |  |   |   |
| I Records, P.O. Box 68 The law requires that the death certifica   | attending phy<br>I for use as th               | by Physician/Med    | IF FEMALE: 23b. Was decedent pregnant  1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy  |  | 23d. Date of                              | delivery  |
| B. B   | ed for   | sicie               | 1 Yes 2 No 4 Pregnant at time of death 5 Other (specify)   |  | Month                                     | Day Year  |
| P. O. at the   | ed by the<br>detached                          | Phy                 | 9 LJ UNKNOWN   |  |   |   |
| ds,  | should be deta                                 |                     | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   | e to the cause of death?  Probably 44 Unknown                 |
| Oro  | should   | Completed           | My Maliting the 3  |  |   |   |
| Red<br>Belaw   | has<br>Je 2                                    | du                  | 1) where i mellings type c   | 24a. Was a<br>autop:<br>perfor         | sy prior                                  | autopsy findings available<br>to completion of cause of<br>h? |
|  | rtificete ha                                   | e Co                | 25. Was case referred to medical 26. Place of Level  | 1 ☐ Yes                                | 2 No 1□                                   | Yes 2□No  |
| $\gamma e_{\mathcal{O}}$ of Vita   | is certific<br>director,                       | To Be               | examiner?  | ath Check on or                        | ne/<br>ence 6 □Other (                    | 241   |
| D of   | After this<br>funeral o                        |                     | 27. Mannay Death 28a. Date of Injury 28b. Time of 28c. Injury at   |  | ow injury occurred                        | <i>эрвспу)</i>  |
| Vision Attending   | tor; Aft                                       | atlo                | 1  |  |   |   |
| Division Atten   | by th  | Certification:      | 3 Suicide 6 Could not be determined 28 e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  | 28f. Location (S<br>City or Tow        | itreet and Number o                       | r Rural Route Number,   |
|  | filled in I                                    |                     |  |  |   |   |
| Div  | To the Funeral Completely filled               | edical              | 29a. Certifier    Certifying Physician: To the best of my knowledge, death occurred at the time, date and place (Check only 2   Medical Examine: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place of the basis of the b | , and due to the durred at the time, o | cause(s) and manne<br>date and place, and | r as stated.<br>due to the cause(s)                           |
| the<br>thin 2  | mple   | Med                 | 29b. Signalure and title of cartifier 1 29c. License number  |  | 29d. Date signed (N                       |   |
| o T with   | F 8  |                     | Now is a   |  | 1) ~19.                                   | -2000   |
|  | 1  |                     | 30. Name and address of gerson was completed cause of death (Item 23a) (Type, Print)   | 2                                      | 16 1                                      |   |
|  | (0)  |                     | Robert A Duncowno 615 W. Mcpml   | 59 B                                   | WARR                                      | MD  |
| was as a   | Sta  | te                  | 31. Date filed (Month, Day, Year) 32. Registrar's Signature  |  | 211                                       | 014   |
| · Andrews  | Registr  | ar                  | DEC 2 3 2005 Acres 15 Aprile   |  | , ,                                       | 1   |

|                 |   | •                 | 1 - For<br>State<br>Registrar   | S                  | tate of                              | Marylan                              |                      | artment<br>tificate        |                    |                            |            | ental Hyg                                    | iene<br>g. No. | 05                          | 4156                       | 55            |
|-----------------|---|-------------------|---|--------------------|--------------------------------------|--------------------------------------|----------------------|----------------------------|--------------------|----------------------------|------------|--|----------------|-----------------------------|----------------------------|---------------|
|                 | Physicia  |                   | 1. Decedent's Name (First, Middle   | , Last)            |                                      |                                      |                      |                            |                    | •                          |            | 2. Date of Dear<br>Month                     | th<br>Dav      | Year                        | 3. Time of                 | Death         |
|                 | /Medic  | _                 | Margaret  |                    |                                      |                                      | Wedder               | ien                        |                    |                            |            | Decembe                                      |                | , 2005                      | 1:35                       | A M           |
| }               | Examin  | er                | 4a. Facility Name (If not institution   | . •                |                                      | •                                    | <b>.</b>             |                            |                    | Location o                 | of Death   |  |                | ounty of Death              |                            |               |
|                 |   |                   | Genesis Elderca  5. Social Security Number  | re- F.             |                                      | ge Cen<br>. Age (In yrs.             |                      | If Under                   | ndal               | If Under                   | 24 Hrs     | P. Data of Righ                              |                | altimo                      |                            |               |
|                 | Funeral<br>Director   |                   | 220–26–9253 Usual Residence of Decedent   |                    | 2 <b>∑</b> F                         | 7 - Age (m yrs.                      |                      | Months                     | Days               | Hours                      | Min.       | 8. Date of Birth<br>(Month, Day<br>March 22, | Year)<br>1931  | Mary                        | place (State dintry) land. | or Foreign    |
|                 | yland   |                   | 10a. State 10b. County  |                    |                                      | 10c. Cit                             | y, Town or Lo        | cation                     |                    |                            |            |  |                |                             | 10d. Inside C              | ity Limits    |
|                 | B Mar   | ctor              | MD Balti  | more               |                                      |                                      | Dundal               | k                          |                    |                            |            |  |                |                             | 1 Tyes                     | 2 <b>∑</b> No |
|                 | death with the Maryland<br>ims 23a or 28a-f show<br>ir must be notified at  | Director          | 10e. Street and Number  |                    |                                      |                                      |                      | 10f. Zip                   |                    |                            |            | 1  | •              | n of What Co                | untry?                     |               |
|                 | s 23s   | rai               | 7607 Merritt Po   |                    |                                      |                                      | 0 10                 |                            | 2122               |                            |            | * 14   | US             |                             |                            |               |
|                 | item<br>item  | Funerai           | 11. Marital Status  1 □ Never Married 2 □ Married   |                    | was Deced<br>Armed Ford<br>1 ☐ Yes 2 |                                      | .5.                  | f Yes, spec                | ent of H           | ispanic Ori<br>in, Mexicar | n, Puerto  | city Yes or No-<br>Rican, etc.)              | 14.            | Race - Amer<br>Black, White |                            |               |
| 980             | urs af  | Þ                 | 3  Widowed 4 □ Divorced   | .50                | If Yes, Give<br>Year or Dat          |                                      |                      | 1 ☐ Yes 2                  | No D               | Specify:                   |            |  | S              | pecify: Whi                 | ite                        |               |
| 21215-0036      | 72 hours after<br>natural', or ite  | Completed         | 15. Deceden<br>(Specify only highe  | t's Educati        | on<br>ompleted)                      |                                      | 16a. Dece            | dent's Usua<br>kind of wor | I Occupa           | ation                      | t of worki | na   | 16b. Kind      | of Business/l               | ndustry                    |               |
| 2               | within<br>ene<br>than "   | nple              | Elementary/Secondary (0-12)   |                    | College (1-4                         | 4or 5+)                              | life.                | DO NOT us                  | e retirea          | 1)                         |            | ng .   |                |                             |                            |               |
|                 | e filed wall Hygier other the   |                   | 12 years 17. Father's Name (First, Middle,  |                    | year                                 | S                                    | Re                   | giste                      | red                |                            |            | (First, Middle, I                            |                | ospital                     | L                          |               |
| Maryland        | s 1 and 2 should be filed within 72 hours after death with the Marylan f Health and Mental Hyglene if Health and Mental Hyglene with them 23 acr 28a-1 show item 27 is marked other than "natural", or items 23a or 28a-1 show other traumatic event. It Medical Exaction must be notified at | o Be              | John A. Pfaff   | Lasij              |                                      |                                      |                      |                            |                    |                            |            | : Burke                                      | waluen Su      | mame)                       |                            |               |
| Ž               | should be<br>nd Mental<br>marked o  | ို                | 19a. Informant's Name/Relations   | hip <i>(Type</i> , | Print)                               |                                      | 19b. Mailie          | ng Address                 | (Street a          |                            |            | I Route Number                               | . City or T    | own, State, Z               | ip Code)                   |               |
|                 | alth a<br>27 is   |                   | Terry Skeen   | Da                 | ughte                                | er                                   |                      |                            |                    |                            |            | d, Dund                                      |                |                             |                            | 22            |
| ore,            | ges 1 a<br>it of Hea<br>if item<br>or othe  | 1 3               | 20a. Method of Disposition  |                    |                                      | 20b. F                               | Place of Dispo       | sition (Nan                | ne of<br>ther plac | (e) I                      | Decen      | ate  | 20c. Loca      | tion - City or              | Town, State                |               |
| <u><u>E</u></u> | nit. Pages<br>scrtment of<br>cortant: if its<br>injury or o   | ١.,               | 1 ☐ Burial 2X Cremation  4 ☐ Donation 5 ☐ Other (S  |                    | oval from Si                         |                                      | view C               |                            |                    |                            | 26, 2      |  | altir          | more Ci                     | ity, MI                    |               |
| Baltimore,      | permit. Par<br>Deportmen<br>Important:<br>any injury once.  |                   | 21. Signature of Funeral Service  | Licensee           | on                                   | nol.                                 | les E                | onnel<br>110 S             | d Address          | unera<br>unera             | al Ho      | me Of D<br>Road, D                           | unda]          | lk,P.A.                     | 21222                      |               |
|                 |   |                   | 23a. Part1. Enter the disease, of<br>shock, or heart failure. List  | complicati         | ions that car                        | used the deat                        |                      |                            |                    |                            |            | r respiratory arr                            |                |                             | Approximat<br>Interval Bet | te<br>ween    |
|                 | Physician   |                   | Immediate Cause (Final disease or condition   |                    | SEI                                  | NII.                                 | F                    | NF                         | P                  | IE                         | N.         | TIA  |                |                             | 5 Onsevand                 | ARS           |
|                 | /Medical<br>Examiner  |                   | resulting in death)   |                    | Due to (o                            | r as a conseq                        | uence of :           | 0 1 (1                     |                    | 0                          | Λο         | 015  |                | _                           |                            | Talle T       |
| 1               | Lxammer   |                   | Sequentially list conditions,   | 6.                 | CKL                                  | PK0                                  | MH                   | SCV                        | LA                 | K                          | H          | 4 DE   | NI             |                             | 11/101                     | CHTY          |
| Г               | bed<br>Isit   | Examine           | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | < −                | E 60                                 | r as a conseq                        | uence or):           | i                          | LIS                | 10                         | FR         | TEN  | 15/            | 1/10                        | 787                        | FA            |
| V               | be executed<br>sician and<br>burial-transit   | xar               | that initiated events<br>resulting in death) Last   | C                  | Due to (o                            | r as a conseq                        | uence of):           |                            |                    | 1                          |            | -1 -1  | ٠ ) ( - )      | 014                         | 201                        | UIJV          |
| 8760            | ate be ex<br>nysician a   |                   |   | l d                |                                      |                                      |                      |                            |                    |                            |            |  |                |                             |                            | 5             |
| 9               | tificate<br>ig phys<br>as the   | edic              |   |                    |                                      |                                      |                      |                            |                    |                            |            |  |                |                             |                            | -1-502-15-    |
| Вох             | death certifica<br>e attending phi<br>d for use as th   | M/UE              | IF FEMALE:<br>23b. Was decedent pregnant  | 23c.               |                                      | ome of pregnath 2 Feta               |                      | Ectopic pr                 | eanancy            |                            |            |  | 230            | d. Date of deir             |                            |               |
|                 | e deal  | Physician/Medical | in the past 12 mosths?<br>1 ☐ Yes 2 ☐ No<br>9 ☐ Unknown   |                    |                                      | nt at time of d                      |                      | Other (sp                  |                    |                            |            |  |                | Month                       | Day                        | Year          |
| P.0.            | that the de<br>sed by the a<br>detached f   |                   | Part II. Other significant conditi  | ons contrib        | outing to dea                        | ath but not res                      | sulting in the u     | nderlying c                | ause aiv           | en in Part I               |            | 23e. Did to                                  | nacco use      | contribute to               | the cause of o             | leath#        |
| Vital Records,  | uires tha<br>signed<br>id be det  | d by              | •   |                    |                                      |                                      |                      | gu                         | acco givi          | orr and and a              | •          |  |                | No 3□Pro                    |                            | nknown        |
| cor             | law requires<br>as been sign<br>2 should be   | ete               |   |                    |                                      | -                                    |                      |                            | -                  |                            |            | 24a. Was a                                   | n Is           | 24h Wara au                 | opsy findings              | available     |
| Re              | 9 9   | Completed         |   |                    |                                      |                                      |                      |                            |                    |                            |            | autops                                       | ned            | prior to c<br>death?        | ompletion of a             | ause of       |
| tal             | sician: Th<br>certificate<br>rector, pag  | 0                 | 25. Was case referred to medica   |                    |                                      |                                      |                      |                            |                    | 26 Place                   | of Opath   | 1 Yes  | 2 No           | 1 🗆 Yes                     | 2 🗆 No                     |               |
| Ž               | d is  | To B              | examiner?   | Hos                | oital:<br>1 □ In                     | patient 2                            | ER/Outpatie          | nt 3 DO                    | A Oth              | 00 1 4                     | ursing Ho  |  |                | Other (Spec                 | ify)                       |               |
| n of            | ding Ph   |                   | 27. Manner of Death  1 Natural 5 ☐ Pendi  |                    | 28a. Date of<br>(Month               | Injury<br>, Day Year)                | 28b. Time o          | f 2                        | 8c. Injun<br>Worl  | y at<br>k?                 | 1          | 28d. Describe h                              | ow injury o    | occurred                    |                            |               |
| sio             | Attending<br>ir death.<br>ector: After<br>by the fune   | cati              | 2 Accident invest   | gation             |                                      |                                      |                      | М                          |                    | Yes 2□                     |            |  |                |                             |                            |               |
| Division        | or Attendated after death   | Certification;    | 4 Homicide  | ined               | 28e. Place o<br>buildin              | of Injury - At h<br>g, etc. (Special | ome, farm, st<br>fy) | eet, factory               | , office           |                            | 1          | 28f. Location (Si<br>City or Town            |                | Number or Ru                | ral Route Nurr             | iber.         |
| _               | To the Hospital or Attending i within 24 hours after death.  To the Funeral Director: After completely filled in by the funer   |                   | 29a. Certifier 1 Certifyi   | ng Physici         | an: To the h                         | pest of my kar                       | owledge deat         | h occurred                 | at the tin         | ne date an                 | nd place   | and due to the c                             | alise/s) an    | nd manner ac                | stated                     |               |
|                 | To the Hospital within 24 hours a To the Funeral completely filled  | edical            |   | Examiner           | On the bas                           | sis of examina                       | ation and/or in      | vestigation,               | in my o            | pinion, dea                | ath occurr | ed at the time, d                            | ate and pl     | ace, and due                | to the cause(s             | 3)            |
|                 | To th<br>withir<br>To th<br>comp  | Me                | 29b. Signature and title of certifie  |                    | 18                                   |                                      | 7                    | 290                        | License            | e number                   | 0          | 2  | 9d. Date s     | signed (Month               | , Day, Year)               | ~             |
| )               |   |                   | Though  | ~ 4                | non                                  | - ~                                  | ( T)                 |                            | 77                 | 141                        | 160        | ) De   | Cem            | ter                         | 222                        | 107           |
|                 | 3   |                   | 30 Nam and address priperson  | Sofort of          | lete Laus                            | of de the (Iter                      | - 50 / 1/4 (4)       | Print/A                    | B                  | LCA                        | TE         | HIGHI  | MAY            | BA                          | -T(MO                      | RE            |
|                 | Sta<br>Regist   |                   | 31. Date filed (Month, Day, Year, DEC 2 5   |                    |                                      | gistrar's Signa                      | ature                | and .                      | , (                | 111                        | 4D         | 2(   | 22             | -2.                         |                            |               |

State of Maryland / Department of Health and Mental Hygiene For State Registrer Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** Gordon Johnson Watt 4:30 A.M December 22,2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Charlestown Care Center Catonsville Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Jan. 16, 1927 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days Hours Months 1 MM 2 □ F 037-14-9761 Yrs. Director Rhode Island 78 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits item 27 is markad other than "natural", or items 23a or 28a-1 ehow other traumatic event. the Medical Examinst must be multified at 1 ☐ Yes 2 No Director Maryland Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 715 Maiden Choice Lane 21228 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 DYes 2 No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: If Yes, Give 1944-46 Year or Dates. Completed by Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry f Health and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Transportation Manager Transportation 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be George L. Watt 2 Edith Johnson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Julia A. Watt 715 Maiden Choice Lane FV306; Catonsville, MD 21228 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a Method of Disposition 5 1 Burial 2 Cremation 3 Removal from State parmit. Page Department of Important: If any injury or \* 4 ☐ Donation 5 ☐ Other (Specify) Garrison Forest 12/28/2005 Owings Mills, MD 21. Signature of Feneral Service Licensee 22. Name and Address of Facility Witzke Funeral Home of Catonsville, 1630 Edmondson Avenue; Catonsville, 23a. Part1. Enter ne disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) claratic **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dua to (or as a consequence of): Examiner the death certificate be executed burial-tran Due to (or as a consequence of): P.O. Box 68760 physician Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? Month Year Day 4 Pregnant at time of death 5 Other (specify) 1 Yes 2 No the 9 Unknown 3 signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed page certificate 1 ☐ Yes 2 ☐ No. 1 ☐ Yes 2 No director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA 1 ☐ Yes 2 ☐ No Other: 4. Nursing Home 5 Residence 6 Other (Specify) 2 this 28a. Date of Injury (Month, Day Year) funeral 28b. Time of 28d. Describe how injury occurred 27 Manner of Death 28c. Injury at Work? Certification; After or Attending 1-2 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation Diractor: / 2 Accident 6 ☐ Could not be 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours after To the Funeral Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certific 2/22/ Chone Care Calouralle, 30 Name and address of person who completed cause of death (Item 23a) (Type, Print) an. 31. Date filed (Month, Day, Year) State Registrar

| 243  |  |   | ype or Print<br>State of Man                         |                             |                              |                     |                       |            |                                 |                          | -                    | le.              |  |
|--|--|---|--|-----------------------------|------------------------------|---------------------|-----------------------|------------|---------------------------------|--------------------------|----------------------|------------------|--|
|  | 1 - For<br>State<br>Registrar  |   |  |                             | Certifica                    |                     |                       |            |                                 | Reg. N                   | 21111                | 5                | 41567  |
| Physician<br>/Medical  | 1. Decedent's Nam<br>Donald V  | ne (First, Middle, Last)<br>Vatson  |  |                             |                              |                     |                       |            | 2. Date of D<br>Month<br>Decemb | Da                       | ay Y<br>6 20         | ear              | 3. Time of Death                                       |
| Examiner   | 4a. Facility Name (  | If not institution, give st   | reet and number)                                     |                             | 4b. Ci                       | y, Town, o          | Location o            |            |                                 |                          | c. County of         | Death            |  |
|  |  | Monford Av  |  |                             |                              | altim<br>Her 1 Year |                       | 24 Hea     |                                 |                          |                      |                  | -  |
| uneral<br>irector  | 5. Social Security Nunknown  | 7-0   | M 2 F  | n yrs. last birth<br>51 Yı  | Month                        |                     | If Under a            | Min.       | 8. Date of B (Month, D          | irth<br>1ay, Year<br>-54 |                      | Birth;<br>Coul   | place (State or Foreign<br>ntry)                       |
| 2 10   | Usual Residence of   | of Decedent<br>10b. County  | 14   | Oc. City, Town              | or Leasting                  |                     |                       |            |                                 |                          |                      |                  |  |
| ritems 23a or 28a-f shorthar at the notified a | MD   | 100. County   |  | Baltim                      |                              |                     |                       |            |                                 |                          |                      |                  | 10d. Inside City Limits 1 XYes 2 No                    |
| or 28  | 10e. Street and Nu   |   |  |                             | 10f.                         | Zip Code            |                       |            |                                 | 10g. C                   | itizen of Wh         | at Cou           | ntry?  |
| 238  | unknowr  | 1   |  |                             | un                           | 12                  |                       |            |                                 | UNK                      |                      |                  |  |
| inei   | 11. Marital Status   | 12  | <ol><li>Was Decedent Eve<br/>Armed Forces?</li></ol> | ar in U.S.                  | 13. Was De<br>If Yes, s      | cedent of H         | ispanic Orig          | gin? (Spe  | cify Yes or N<br>Rican, etc.)   | lo-                      | 14. Race -<br>Black. | Americ<br>White, |  |
| Examination if   |  | ried 21 Married 4 Divorced  | 1 ☐ Yes 2 XNo If Yes, Give Year or Dates:            |                             |                              | 21 No               | Specify:              |            |                                 |                          | Specify:             |                  |  |
| or the Medical in the | (Spe   | 15. Decedent's Education only highest grade   | ation<br>completed)                                  | (                           | Decedent's U<br>Give kind of | work done           | durina most           | t of worki | ng                              | 16b. I                   | Kind of Busi         | ness/In          | dustry   |
| m Pen  | Elementary/Sec   |   | College (1-4or 5+)                                   |                             | life. DO NO                  |                     | 1)                    |            |                                 | _                        |                      |                  |  |
| S  | 12th   | (First, Middle, Last)   |  | C                           | ustoc                        | lan                 | 19 Motho              | r's Nome   | (First, Middl                   |                          | merc                 |                  |  |
| ed ot  |  | Robinson  |  |                             |                              |                     |                       |            |                                 |                          | n Sumame)            |                  |  |
| marke<br>matic   |  | James Robinson  Sophia Watson  19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Sta |  |                             |                              |                     |                       |            |                                 |                          |                      |                  | 0-11   |
| n 27 ts  | Ella Horn 6119 McBeth Dr. Balto. MD 21239  20a Method of Disposition 20b Place of Disposition (Name of Date 20c Location - Circ  |   |  |                             |                              |                     |                       |            |                                 |                          |                      |                  | Code)  |
| Department of results and wenter projects.  Department of results and wenter by years  any injury or other traumatic event, tra Medical Exercipar main be notified at once.  To Be Completed by Funeral Director   | 20a. Method of Disposition  1 \( \text{Surial 2 \subseteq Cremation 3 \subseteq Removal from State 4 \subseteq Donation 5 \subseteq Other (Specify) } \)  20b. Place of Disposition (Name of cemetery, crematory or other place) MT. Carmel  20c. Location - City or Town, State Dundalk, MD   |   |  |                             |                              |                     |                       |            |                                 |                          |                      |                  |  |
| imports<br>any inji  | 21. Signature of F   | unefal Service License  | las Az   |                             |                              |                     |                       |            | ley (                           |                          |                      |                  |  |
|  | 23a. Parti. Enter  | the disease, or complic<br>art failur. List only one  | ations that wused the                                | e death. Do no              | ot enter the m               | ode of dyin         | g, such as            | cardiac o  | r respiratory                   | arrest,                  |                      |                  | Approximate<br>Interval Between                        |
| rsician<br>ledical   | Immediate Cause<br>disease or conditi-<br>resulting in death)  | (Final on   | _othero  | scler                       | otic                         |                     |                       |            | ular                            |                          | Spes                 | ی                | Onset and Death  |
| iminer<br>ច  | Sequentially list co   | onditions, b.   | Due to (or as a c                                    | onsequence of               | ):                           |                     |                       |            |                                 |                          |                      | 4                |  |
| en end<br>rial-transit<br>Examin   | if any, leading to it cause. Enter Und Cause (Disease of that initiated event  | rinjurý<br>s c.   |  | ·                           | ,                            |                     |                       |            |                                 |                          |                      |                  |  |
| ysicie<br>ie bur<br>cal  | resulting in death)  | Last d.   | Due to (or as a c                                    | onsequence of               | ):                           |                     |                       |            |                                 |                          |                      |                  |  |
| as the   | IE EENALE.   |   |  |                             |                              |                     |                       |            |                                 |                          |                      |                  |  |
| d by the attending physici<br>letached for use as the bu<br>letached for We as the bu  | F FEMALE: 23b. Was decedent pregnant in the past 12 months?   1   Yes   2   No   9   Unknown   23c. If yes, outcome of pregnancy   23d. Date of death   3   Ectopic pregnancy   Month   4   Pregnant at time of death   5   Other (specify)   Month   9   Unknown   9   Un |   |  |                             |                              |                     |                       |            |                                 |                          |                      | ery<br>Day Year  |  |
|  |  |   |  |                             |                              |                     |                       |            |                                 |                          | he cause of death?   |                  |  |
| been sig<br>should by  | g chronic narcotism  |   |  |                             |                              |                     |                       |            |                                 | Yes 2                    | 2 □ No 3             | □ Prot           | pably 4 Kunknown                                       |
| age 2  | 1  |   |  |                             |                              |                     |                       | _          |                                 | opsy<br>formed?          | prie<br>de:          | or to co<br>ath? | psy findings available<br>mpletion of cause of<br>2 No |
| ector.   | 25. Was case refe<br>examiner?   |   |  |                             |                              | 7                   |                       | of Death   | Check only                      | onel                     |                      |                  |  |
| # P   F  | MXYes 2  | JNO   | spital: 1   Inpatient                                | 2 ER/Outp                   |                              |                     | 4 🗆 Nu                |            | me 5□Res                        |                          |                      |                  | y) Scene   |
| arter deam. I Director: After the in by the funera   | 27. Manner of Dea<br>1 Natural<br>2 Accident   | 5 Pending investigation   | 28a. Date of Injury<br>(Month, Day Y                 | ear) 28b. Tir<br>ear) Inj   | me of<br>ury<br>M            | 28c. Injun<br>Wor   | yat<br>k?<br>Yes 2 ∐! |            | 28d. Describe                   | how inju                 | ury occurred         |                  |  |
| i Directo<br>d in by th  | 3 ☐ Suicide<br>4 ☐ Homicide  | 6 Could not be determined   | 28e. Place of Injury<br>building, etc. (             | - At home, farr<br>Specify) | n, street, fact              | ory, office         |                       | -          | 28f. Location<br>City or To     | (Street a                | and Number<br>te)    | or Rura          | al Route Number,                                       |

Division of Vital Records, P.O. Box 68760, To the Hospital within 24 hours To the Funeral completely filled

Baltimore, Maryland 21215-0036

29a Certifier 1 Certifying Physician: To the best of my knowledge death occurred at the time date and clace, and due to the cause(s) and manner as stated.

\*\*Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

December, 7, 2005 OCME

32. Regi

111 Penn Street Baltimore, Maryland 21201

State Registrar

DHMH 17 Rev 1/2001

Medical

31. Date filed (Month, Day, Year)
DEC 2 3

|  | 1-          | For<br>State<br>Registrer  | State of Ma  |                 | Departm                                       |  | leaith and                                  | Mental H                            | ygiene<br>Reg: No                | ข้ากร   | 41568   |
|--|-------------|--|--|-----------------|---|--|---|-------------------------------------|----------------------------------|---|---|
| Physician<br>/Medical<br>Examiner  | 4a.         | Decedent's Name (First, Middle, Last)  Facility Name (If not institution give so Copper Richards)  Copper Richards  Social Security Number 6. Sex  | wolf<br>street and number)   | (In yrs. last b |   | SYKE!                                    | or Location of Dea                          |                                     | ber 40                           | County of Dea   | 011   |
| Funeral<br>Director  | 1 Usi       |  | M 2 XF 61  |                 |   | nths Days                                | Hours Min                                   | 8. Date of B<br>(Month, D<br>July 2 | 25 19                            | )44 GA  | thplace (State or Foountry)  10d. Inside City Li    |
| or 28a-f show  |             | Md Carroll  e. Street and Number   |  | Sykesy          |   | f. Zip Code                              |   |                                     |                                  | tizen of What Co                                      | 1 XYes 2  |
| within 72 hours after death with the Maryland ane. than "natural", or itams 23a or 28a-f show the Madical Expirient must be notified at impleted by Funeral Director | 11.         | Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced   | 12. Was Decedent Ev<br>Armed Forces?<br>1 □ Yes 2 □ No<br>If Yes, Give X<br>Year or Dates:   |                 |   | 2178 Decedent of Hispecify Cub es 2 17No | 1/3/3/3/3/3/3/3/3/3/3/3/3/3/3/3/3/3/3/3     | Specify Yes or N<br>to Rican, etc.) | US                               | 14. Race - Ame<br>Black, Whit<br>Specify: wh          | e, etc.   |
| 교육들의 (2)   |             | 15. Decedent's Edu<br>(Specify only highest grade  | cation<br>e completed)<br>College (1-4or 5+<br>+5  |                 | a. Decedent's<br>(Give kind of<br>life. DO No | of work done<br>OT use retire            | during most of wo                           | rking                               |                                  | and of Business                                       | /Industry   |
| be fill hit hit hit hit out out out out out out out out out ou   | I           | Father's Name (First, Middle, Last) David C. Wolfe a. Informant's Name/Relationship (Ty,   | no Print)  | 10              | Ob. Mailine Ad                                | drana (Ctrant                            | 18. Mother's Na Margaret and Number or R    | Waters                              | 3                                |   | 7-0-11  |
| 1 and 2:<br>Health ar<br>am 27 is<br>thar trau   | _ A         | Ann Wolfe (sister  |  | 1               | 18 N. C                                       | heste                                    | St., Ba                                     |                                     | , Md                             |   |   |
| permit. Pages<br>Department of I<br>Important: If its<br>any injury or o<br>QDCS.  |             | 1 ☐ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)  Signature of Funeral Service License  |  | All (           | 22. Nan                                       | Cremat                                   | cion 12-2<br>ss of Facility Ha<br>195 Sykes | 3-05<br>aight Fu                    | Syk                              | esville<br>1 Home                                     | , Md  |
| cate be executed by spician and the burial-transit and the burial-transit and dical Examiner   | Se if a can | mediate Cause (Final sease or condition sulting in death)  quentially list conditions, my, leading to immediate use. Linter funderlying use (Disease or injury it indiated events sulting in death) Last | Due to (or as a Due to (or a) Due to (or as a Due to (or a) Due to | consequence     | e of):  | mer                                      | rtia  |                                     |                                  |   | Onset and Dea                                       |
| d by the attending phylelached for use as th   |             | FEMALE: b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9  Unknown   | 3c. If yes, outcome of<br>1□Live birth 2<br>4□Pregnant at tir<br>9□Unknown   | ☐ Fetal deat    |   | pic pregnancy<br>or (specify)            | ′   |                                     |                                  | 23d. Date of del<br>Month                             | ivery<br>Day Year                                   |
| be of pe of  | S           | t II. Other significant conditions con   | tributing to death but   | not resulting   | in the underly                                | ing cause giv                            | en in Part I.                               |                                     |                                  | 1   | the cause of death                                  |
| the law ate has b page 2 sl  | 25          | Was case referred to medical   |  |                 |   |  | 00.7 4.8-                                   | 24a. Was<br>auto<br>perf<br>Yes     | opsy<br>ormed?<br>2 \( \text{No} | prior to death?                                       | topsy findings avai<br>completion of cause<br>22000 |
| After this funeral dir   |             | examiner?  1 Yes 2 No H  Manner of Death  1 Natural 5 Pending 2 Accident investigation   | ospital:<br>1  Inpatient<br>28a. Date of Injury<br>(Month, Day 1   | 28b.            | Outpatient 3[<br>. Time of<br>Injury          | 28c. Injur<br>Wor                        | er: 4 Nursing h                             |                                     | idence                           | 6 □Other (Spec<br>ry occurred                         | cify)   |
| S S S S  | 200         | 3 Suicide 6 Could not be determined  a. Certifier Certifying Physics   | 28e. Place of Injury<br>building, etc.   | (Specify)       |   |  |   | City or To                          | wn, State                        | o)  | iral Route Number,                                  |
| To the Hosp<br>within 24 hou<br>To the Fune<br>completely fil  |             | (Check only one)  2 Medical Examir  one)   | sician: To the best of<br>ner: On the basis of e<br>and manner state   | xamination a    | ge, death bcct<br>and/or investig             | ation, in my o                           | pinion, death occu                          | urred at the time                   | , date and                       | and manner as<br>d place, and due<br>te signed (Monti | to the cause(s)                                     |
| 17   | 30.         | Name and address of person who co  | MAD mpleted cause of dea   | nth (Item 23a)  | ) (Type, Print)                               | 0005                                     | 8137  |                                     | 12                               | 19/0  | 5   |
| State<br>Registrar   | 31.         | Date filed (Month, Day, Year)  | 32. Registrar  | s Signature     | ve st   | 307                                      | wes   | ten.rst                             | 2                                | MO  | 21157   |

| LITC  | ۷۷۱ تانکلالر  |                            | For State Registrar  | State of                   | of Marylar                                   |                                   | artment of He  |  | d Mental Hy                                  | giene                                 | 5 4156                                     | 9      |
|---|---|----------------------------|--|----------------------------|--|-----------------------------------|--|--|--|---------------------------------------|--|--------|
|   |   | .\$                        | Decedent's Name (First, Middle   | e, Last)                   |  |                                   |  |  | 2. Date of De                                | eath                                  | 3. Time of De                              | ath    |
|   | Physici<br>/Medio   |                            |  |                            |  |                                   |  |  |  | М                                     |  |        |
|   | Examir  |                            | 4a Facility Name (If not institution Windsor Court A   |                            | 7206   |                                   | 4b. City, Town, or I   | Location of D                            |  | 4c. County                            |  |        |
|   | y . *   | 4                          | 2111 Garrison B  | oulevard                   |  | Baltimor                          |  |  |  |                                       | N/A  |        |
|   | Funeral Director  |                            | 5. Social Security Number 211–40–5792  | 6. Sex<br>1 ★ M 2 ☐ F      | 7. Age (In yrs. 55                           | last birthday)<br>Yrs.            | If Under 1 Year<br>Months Days   | Hours 1                                  | Min. 8. Date of Bi                           | 950 <sup>ar)</sup>                    | 9. Birthplace (State or Fo                 | oreign |
| 036   | and *   |                            | Usual Residence of Decedent  10a. State 10b. County  |                            | 10c Ci                                       | ty, Town or Lo                    | ocation  |  |  |                                       | 10d. Inside City L                         | imita  |
|   | d within 72 hours atter death with the Maryland<br>liene<br>t than "natural", or Iteme 23a or 28a-f show<br>the Mexical Exacilian relate incilliad at | ō                          |  |                            |  |                                   |  |  |  |                                       | 1 ☑ Yes 2[                                 |        |
|   |   | Director                   | 10e. Street and Number   |                            |  | DIIII III                         | 10f. Zip Code  |  |  |                                       | What Country?                              |        |
|   |   |                            | 2111 GARRISON  | BLVD. AP                   | T 206  |                                   | 21215  | 5  |  | USA                                   |  |        |
|   |   | by Funerai                 | 11. Marital Status  1 Never Married 2 Marr 3 Widowed 4 Divorced  | Angued F                   | 2 □ No<br>ive                                |                                   | Was Decedent of His<br>If Yes, specify Cuban<br>1 ☐ Yes 2 ★ No                   | panic Origin<br>, Mexican, P<br>Specify: | ? (Specify Yes or No<br>ruerto Rican, etc.)  |                                       | e - American Indian,<br>ck, White, etc.    |        |
| 2-0   |   | eted                       | 15. Decedent's Education 16a. Decedent's Usual Oc<br>(Specify only highest grade completed) (Give kind of work de  |                            |  | dent's Usual Occupat              | Occupation 16b   |  |  | usiness/Industry                      |  |        |
| 21215-0036  |   | Completed                  | Elementary/Secondary (0-12)  |                            | [1-40[5+]                                    |                                   | (Give kind of work done during most of workin life. DO NOT use retired)  LABORER |  |  | CON                                   | CONSTRUCTION                               |        |
|   | be filed<br>tal Hygi<br>d other<br>event, t   | Вес                        | 17. Father's Name (First, Middle,  | Last)                      |  |                                   |  | 18. Mother's                             | Name (First, Middle                          | , Maiden Sumam                        | 1e)  |        |
| Maryland  |   | 101                        | CHARLES BROWN  |                            |  |                                   |  |  | IZABETH W                                    |                                       |  |        |
| Mar   | 12 sh<br>h and<br>7 is rr<br>traur  |                            | 19a. Informant's Name/Relations  |                            | aramen)                                      |                                   | ng Address (Street ar  |  |  |                                       |  |        |
|   | 1 an<br>Heal<br>Brn 2<br>ther   |                            | CAROLYN D. WA  | SHINGION (                 | 20b. I                                       | Place of Dispo                    | sition (Name of  |  | Date   |                                       | YLAND 20747<br>City or Town, State         | -      |
| Baltimore,  | 0 0 = =   |                            | 1 Burial 2 Cremation 4 Donation 5 Other (\$  |                            | State  |                                   | natory or other place,   | !  | 10 2005                                      |                                       |  |        |
| alti  | 교육한글 .  |                            | 21. Signature of Funeral Service   |                            |  |                                   | EMATORY<br>I. Name and Address   |  | -19-2005  <br>PHILLTPS                       | _BALI IMO.<br>FIINERAI.               | RE, MARYLAND<br>HOME, P.A.                 | ,      |
| m   | Depa<br>Impo<br>eny i   |                            | forat  | ta U.                      | This   | V                                 |  |  |  |                                       | MARYLAND 212                               | 217    |
| Physician //Medical Examiner  23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory one cause on each line. List only one cause on each line. List only one cause on each line. List only one cause on each line. Due to (or as a consequence of):  Due to (or as a consequence of): |   |                            |  |                            | diac or respiratory a                        |                                   | Approximate<br>Interval Betwee<br>Onset and Deat                                 |  |  |                                       |  |        |
| Vital Records, P.O. Box 68760,  | at the death certificate be executed<br>by the ettending physicien and<br>tached for use as the burial-transit  | Physician/Medical Examiner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | С                          | (or as a consec                              |                                   |  |  |  |                                       |  |        |
|   |   |                            |  |                            |  |                                   | death 3 Ectopic pregnancy  |  |  |                                       | 23d. Date of delivery<br>Month Day Year    |        |
|   | signed<br>d be de   | by                         | Part II. Other significant condition   | ns contributing to d       | eath but not res                             | ulting in the ur                  | nderlying cause given  | in Part I.                               | 23e. Did t                                   | A . c                                 | nbute to the cause of death                |        |
|   |   | Completed                  | Complet  |                            |  |                                   |  | 24a. Was an autopsy performe             |  | osy p                                 |  |        |
| Z.  | Physician: Th<br>this certificete<br>al director, pag   | o Be                       | 25. Was case referred to medical examiner? 1 ∑XYes 2 ☐ No  | Hospital:                  |  | len (a                            | Other  |  | Death (Check only of                         |                                       | , A.L.                                     |        |
| of  |   | -                          | 27. Manner of Death  | 28a. Date                  | ol Injury                                    | ER/Outpatien<br>28b. Time of      | t 3 DOA 28c. Injury a Work?  | 4   Nursin                               | g Home 5 Resident                            | dence 6X_Othe                         | er (S <i>pecify)</i> At SCET<br>ed         | ne     |
| Division  | Attending r death. ector: After by the fune   | ertification:              | 1 □Natural 5 □ Pendin-<br>2 □ Accident investig  | 4                          | lill X                                       | Injury 0335                       | M 1 □ Ye   |  | Sorbin                                       | ect s                                 | 15   |        |
| ivis  | i or Atten<br>after deat<br>Director:<br>I in by the  | tific                      | 3 ☐ Suicide 6 ☐ Could r<br>determine   | and 289. Place             | of Injury - At h                             | ome larm, stre                    | eet, lactory, office   |  | 28l. Location (S                             | Street and Number                     | er or Rural Route Number,                  |        |
|   | Hospital or 44 hours afte Funeral Dir 1619 tilled in 1  | O                          |  | -                          | INA  | resi                              | dence  |  | Winks  | CF.AT.                                | #206 42                                    | 15     |
|   | To the Hospital or Attenwithin 24 hours after deation to the Funeral Director: completely tilled in by the  | edicai                     | 29a. Certifier 1 Certifyin (Check only 2 Medical 1   | <b>Examiner</b> : On the b | e best of my knowasis of examination stated. | wiedge, death<br>ition and/or inv | occurred at the time<br>restigation, in my opin                                  | , date and pl<br>nion, death o           | ace, and due to the<br>eccurred at the time, | cause(s) and man<br>date and place, a | nner as stated.<br>and due to the cause(s) |        |
|   | To the I  | Σ                          | 29b. Signature and title of certifier  | la la an                   | 1  |                                   | 29c. License r<br>OCM  |  |  | _                                     | (Month, Day, Year)                         |        |
|   | 7   |                            | 30. Name and address of person   | who completed caus         | se of death (Iten                            | п 23а) (Туре,                     | Print) 111 Per   | nn Str                                   |  |                                       | Maryland 2120                              | 01     |
| 3   | Sta   |                            | 31. Date liled (Month, Day, Year)  | 32 F                       | Registrar's Signa                            | ature A.                          | N. I   |  |  |                                       |  |        |
|   | Registr   | di                         | DEC 2 3  | ZUUD KW                    | 1.40 0 ,63                                   | 100                               |  |  |  |                                       |  |        |

| Physician   Medical     Examiner     4a. Facility Name (If not institution, give street and number)     CHESAPEAKE HOPSPICE HOUSE     5. Social Security Number     Director     5. Social Security Number     051-07-7071     1   | Reg. No.  Date of Death 3, Time of D  | _                                    |  |  |  |  |  |  |
|--|---|--------------------------------------|--|--|--|--|--|--|
| TILLIE  ZIPPER  DE  4a. Facility Name (If not institution, give street and number)  CHESAPEAKE HOPSPICE HOUSE  LINTHICUM  5. Social Security Number  051-07-7071  CHARACTER SECURITY Number  6. Sex 1  |   | eath                                 |  |  |  |  |  |  |
| 4a. Facility Name (If not institution, give street and number)  CHESAPEAKE HOPSPICE HOUSE  CHESAPEAKE HOPSPICE HOUSE  LINTHICUM  5. Social Security Number  051-07-7071  Contractor  6. Sex  1 Months Days Hours Min. 04  Usual Residence of Decedent  | ECEMBER 21, 2005 12:00  | <b>P</b> M                           |  |  |  |  |  |  |
| Funeral 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1 Months Days Hours Min. 04  Director Usual Residence of Decedent  | 4c. County of Death   |                                      |  |  |  |  |  |  |
| Director    O51-07-7071   1   M 2   F   86   Yrs.   Months Days Hours Min.   O4  | ANNE ARUNDEL  |                                      |  |  |  |  |  |  |
| Usual Residence of Decedent  | Date of Birth (Month, Day, Year)  9. Birthplace (State or Incountry)  | Foreign                              |  |  |  |  |  |  |
| Usual residence of Decedent  | 4/08/1919 NY  |                                      |  |  |  |  |  |  |
| 10a. State 10b. County 10c. City, Town or Location   | 10d. Inside City  | Limits                               |  |  |  |  |  |  |
| FL BROWARD TAMARAC   | 1 □ Yes 2   | No No                                |  |  |  |  |  |  |
| FL BROWARD TAMARAC  106. Street and Number 10f. Zip Code   | 10g. Citizen of What Country?   |                                      |  |  |  |  |  |  |
| 6303 N.W. 72nd AVENUE 33319  | U.S.A.  |                                      |  |  |  |  |  |  |
| 6303 N.W. /2nd AVENUE 33319  11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1   Never Married   1   Never Married   2   Married   1   Yes   2   Maried   1   Yes   2   Married   1   Married   1   Yes   2   M | y Yes or No-<br>an, etc.) 14. Race - American Indian,<br>Black, White, etc.   |                                      |  |  |  |  |  |  |
| 1 Never Married 2 Married 1 Yes 2 M No If Yes, Give 1 Yes 2 M No Specify: Year or Dates:   | Specify: WHITE  |                                      |  |  |  |  |  |  |
| TAMARAC  10a. State 10b. County 10c. City, Town or Location  TAMARAC  10b. Street and Number 10f. Zip Code  6303 N.W. 72nd AVENUE 33319  11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1   Yes, specify Cuban, Mexican, Puerto Ricar 1   Yes 2   No   Year or Dates: 15. Decedent's Education (Specify only highest grade completed)  15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)  17  | 16b. Kind of Business/Industry  |                                      |  |  |  |  |  |  |
| (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired)  Elementary/Secondary (0-12)  College (1-4or 5+)   |   |                                      |  |  |  |  |  |  |
| 15. Decedent's Education (Specify only highest grade completed)  [Specify only highest grade completed]  | LAW   |                                      |  |  |  |  |  |  |
| 17. Father's Name (First, Middle, Last)  | irst, Middle, Maiden Surname)   |                                      |  |  |  |  |  |  |
| MORRIS  19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Ro  | SPRINGER  |                                      |  |  |  |  |  |  |
| The state of the s |   |                                      |  |  |  |  |  |  |
|  |   |                                      |  |  |  |  |  |  |
|  | only or romi, only  |                                      |  |  |  |  |  |  |
|  | -65 NORTH LAUDERDALE, F   | L                                    |  |  |  |  |  |  |
| M 80 E E S   | EVINSON & BROS., INC.   | 0                                    |  |  |  |  |  |  |
| 23a, Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or res   | 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  Approximate   |                                      |  |  |  |  |  |  |
| Immediate Cause (Final   | shock, or heart failure. List only one cause on each line.  Interval Between Onset and Death  |                                      |  |  |  |  |  |  |
| /Medical disease or condition resulting in death)  Due to (or as a consequence of):  | Sylver Sylver   | an                                   |  |  |  |  |  |  |
| Examiner   |   |                                      |  |  |  |  |  |  |
| Community the flow and different to the community of the  |   |                                      |  |  |  |  |  |  |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying   |   |                                      |  |  |  |  |  |  |
|  |   |                                      |  |  |  |  |  |  |
| Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  |   |                                      |  |  |  |  |  |  |
| Construction of the constr |   |                                      |  |  |  |  |  |  |
| Construction of the constr | 23d. Date of delivery   |                                      |  |  |  |  |  |  |
| Construction of the constr | 23d. Date of delivery<br>Month Day Ye   | oar .                                |  |  |  |  |  |  |
| Construction of the constr |   | <b>v</b> ar                          |  |  |  |  |  |  |
| Construction of the constr |   |                                      |  |  |  |  |  |  |
| C  | Month Day Ye  | ath?                                 |  |  |  |  |  |  |
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| C  | Month Day Ye  23e. Did tobacco use contribute to the cause of deal  1 Yes 2 No 3 Probably 4 Un  24a. Was an autopsy performed? prior to completion of caudeath?  1 Yes 2 No 1 Yes 2 No 2 N  | ath?<br>iknown<br>vailable           |  |  |  |  |  |  |
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| Cause (Usease or Injury that initiated events resulting in death) Last  Cause (Usease or Injury that initiated events resulting in death) Last  Cause (Usease or Injury that initiated events resulting in death) Last  Cause (Usease or Injury that initiated events resulting in death) Last  Cause (Usease or Injury that initiated events resulting in death) Last  Cause (Usease or Injury that initiated events resulting in death) Last  Cause (Usease or Injury that initiated events resulting in death) Last  Cause (Usease or Injury that initiated events resulting in death) Last  Cause (Usease or Injury that initiated events resulting in death) Last  Cause (Usease or Injury that initiated events resulting in death) Last  Cause (Usease or Injury that initiated events resulting in death) Last  Cause (Usease or Injury that initiated events resulting in death) Last  Cause (Usease or Injury that initiated events resulting in death) Last  Cause (Usease or Injury that initiated events resulting in death) Last  Cause (Usease or Injury that initiated events resulting in death) Last  Cause (Usease or Injury that initiated events resulting in death) Last  Cause (Usease or Injury that initiated events resulting in death) Last  Cause (Usease or Injury that initiated events resulting in death) Last  Cause (Usease or Injury that initiated events resulting in death) Last  Cause (Usease or Injury that initiated events resulting in death) Last  Cause (Usease or Injury that Injury at Injury at Injury that Injury at Injury that Injury at Injury that Injury that Injury at Injury that Injury at Injury that Injury at Injury at Injury that Injury at Inj | Month Day Ye  23e. Did tobacco use contribute to the cause of deal  1 Yes 2 No 3 Probably 4 Un  24a. Was an autopsy performed? 1 Yes 2 No 1 Yes 2 No  24b. Were autopsy findings av prior to completion of caudeath? 1 Yes 2 No  24check only one)  | ath?  vailable use of                |  |  |  |  |  |  |
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05-8485 B.K.S HARRY APPEL

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

| RR.                 | Y APPEI  |                   | 1 - For<br>State<br>Registrar   | State of Mai  | yland / Dep<br><i>Ce</i>  | artment of<br>rtificate o               | Health and f Death                         |   | giene () () ()                          | 5 41571   |  |
|---------------------|--|-------------------|---|---|---|---|--|---|---|---|--|
| п                   | Physici  | ian               | Decedent's Name (First, Middle, Last)   |   |   |   |  | 2. Date of Dea<br>Month   |   | 3. Time of Death  |  |
|                     | /Medi  | cal               |   | eorge   | Appel   | 45 03: 7                                | and another of D                           | DEC.  | 16, 200                                 |   |  |
|                     | Examin   | ner               | 4a. Facility Name (If not institution, give : MEMORIAL HOSPITAL   | street and number)  |   | CUMBE                                   | , or Location of De<br>RLAND               | atn   | 4c. County of Death ALLEGANY            |   |  |
|                     | Funeral  |                   | Social Security Number 6. Sex   |   | (In yrs. last birthday)   | If Under 1 Yea                          |  |   | h                                       | 9. Birthplace (State or Foreign   |  |
|                     | Director   |                   | 220-26-9857   | <sup>1M 2□ F</sup> 70   | Yrs.  | Months Day                              | rs Hours M                                 | May 30  | , 1935                                  | 9. Birthplace (State or Foreign Country)                                |  |
|                     | and *  |                   | Usual Residence of Decedent  10a. State 10b. County   |   | IOc. City, Town or Lo   | ocation                                 |  |   |   | 10d. Inside City Limits   |  |
|                     | Mary!  | ō                 | MD Allegany   |   |   | perland                                 |  |   |   | 1√ Yes 2 No   |  |
|                     | 1 the  | Director          | 10e. Street and Number  |   |   | 10f. Zip Code                           | )  |   | 10g. Citizen of Wh                      | nat Country?  |  |
|                     | hours after death with the Maryland<br>lural, or Iteme 23a or 28a-1 ehow<br>al Examinar must be inclified at   |                   | 1023 LaFayette Ave  | enue  |   |   | 21502                                      |   | USA                                     | 4   |  |
|                     | ral', or iteme 23a or 28a-f ehow<br>Examinat must be notified at   | Funerai           |   | 12. Was Decedent Ev<br>Armed Forces?                                | er in U.S. 13.  | Was Decedent o                          | f Hispanic Origin?                         | (Specify Yes or No-<br>erto Rican, etc.)  | 14. Race -                              | - American Indian,<br>White, etc.                                       |  |
| 36                  | s afte   | by Fu             | 1 ☐ Never Married 2 ☐ Married 3 ☑ Wiobwed 4 ☐ Divorced  | 1 ☐ Yes 2 ☐ No<br>If Yes, Give X                                    |   | 1□Yes 2 N                               |  | , , ,   | Specify:                                |   |  |
| Ş                   | within 72 hour<br>iene.<br>rthan "natural"<br>the Madical Ex   | To Be Completed t | 15. Decedent's Edu  | Year or Dates:  | 16a, Dece   | dent's Usual Occ                        | unation                                    |   | 16b. Kind of Busi                       |   |  |
| 215                 |  |                   | (Specify only highest grade<br>Elementary/Secondary (0-12)  |   | (Give   | kind of work dor<br>DO NOT use reti     | e during most of w                         | vorking   | TOD. TAING OF DUSI                      | niosa nidustry  |  |
| 21                  |  |                   | 12  |   | labore  |   |  |   | Tire Co.                                |   |  |
| nd                  | e da a   |                   | 17. Father's Name (First, Middle, Last)   |   |   |   |  | ame (First, Middle,   |   |   |  |
| <u>\</u>            |  |                   |   |   |   |   |  | S Rinker Appel  Rural Route Number, City or Town, State, Zip Code)              |   |   |  |
| Maryland 21215-0036 | 473  | 1 8               | 19a. Informant's Name/Relationship (Ty)  Deborah Ritchie  | daugh   |   | ng Address (Stree<br>Dak Stree          |  | Rural Route Numbe<br>Cumb   | r, City or Town, St<br>erland           | MD 21502  |  |
|                     | of Health<br>Item 27<br>other tr   |                   | 20a. Method of Disposition  | adagii  | 20b. Place of Dispo   | sition (Name of                         | Ţ  | Date  | 20c. Location - Ci                      |   |  |
| ê<br>E              | 2 = 5  |                   | 1 Surial 2 □ Cremation 3 □ R<br>4 □ Donation 5 □ Other (Specify)  | emoval from State   | Sunset Men  | matory or other p<br>norial Park        |  | 12/20/2005  | Cumberl                                 | -   |  |
|                     | # 등 발 글  |                   | 21. Signature of uneral Service License   | 9/1/,   |   |   | Iress of Facility<br>Elli Funeral          | _   | ·                                       |   |  |
| <u> </u>            | Depermination of the second of | 1                 | 1/1/1/1/1/  | LMG   |   | 108 Vi                                  | rginia Aven                                | ue: Cumberl   | and, MD 21                              | 1502  |  |
|                     | Physician<br>/Medical<br>Examiner  |                   | 23a. Part. Enter the disease, or compliance for loan failure. List only or Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions. | Doalo (or as a  | Sive athorometers of):  |   |  | ,   |   | Approximate Interval Between Onset and Death                            |  |
| 38760, <            | death certificate be executed<br>e ettending physicien and<br>of for use as the buriat-transit   | dicai Examiner    | d   |   |   |   |  |   |   |   |  |
|                     |  | Physician/Med     | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2   No 9   Unknown   | 3c. If yes, outcome of 1 Live birth 2 4 Pregnant at tir             | Fetal death 3   | Ectopic pregnar<br>Other (specify)      | icy  |   | 23d. Date of Month                      | · ·   |  |
| Ö,                  | requires that the<br>een signed by th<br>nould be detache  | by Pi             | Part II. Other significant conditions con   | tributing to death but  | not resulting in the u  | nderlying cause o                       | jiven in Part I.                           | 23e. Did to   | bacco use contribu                      | ute to the cause of death?  |  |
| ord                 | w requires to been signer should be  | e Completed       | diabotes mellitus   |   |   |   |  | . 1□Y   | 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Ø Unknown |   |  |
| I Rec               | The law<br>ete hes b<br>page 2 sl  |                   | 25. Was case referred to medical  |   |   |   | =======================================    |   | med? dea                                | re autopsy findings available or to completion of cause of th? Yes 2 No |  |
| >                   | Physicien:<br>this certific<br>ral director,   | To B              | examiner?   | ospital:  | 2 ☑ ER/Outpatier  | it 3□ DOA C                             | M  | eath (Check only or<br>Home 5 Resid   | -                                       | (Casald   |  |
| 9                   | g Phy<br>erthi<br>eralo  |                   | 27. Manner of Death   | 28a. Date of Injury<br>(Month, Day )                                |   |   |  |   | ow injury occurred                      |   |  |
| <u>.</u>            | Attending r deeth. ector: After by the fune  | atic              | 1 Natural 5 Pending investigation   | (Month, Day)  | (ear) Injury  |   | Yes 2□No                                   |   |   |   |  |
|                     | To the hospital or Attanding Physicien:<br>within 24 hours after deeth.<br>To the Funeral Director: After this certific<br>completely filled in by the funeral director.   | Certification;    | 3 ☐ Suicide 6 ☐ Could not be<br>4 ☐ Homicide determined   | 28e. Place of Injury<br>building, etc.                              | lace of Injury - At home, farm, street, factory, office uilding, etc. (Specify) |   |  | 28f. Location (Street and Number or Rural Route Number,<br>City or Town, State) |   |   |  |
|                     | Hosp<br>24 hou<br>Funer<br>etely fill  | edicai            | 29a. Certifier  (Check only one)  1 Certifying Physical Examination   | icien: To the best of or<br>ter: On the basis of exand manner state | kamination and/or in  | n occurred at the<br>vestigation, in my | time, date and place<br>opinion, death occ | ce, and due to the c<br>curred at the time, d                                   | ause(s) and mann<br>ate and place, and  | er as stated.<br>I due to the cause(s)                                  |  |
|                     | To the within 2. To the I complet  | Me                | 29b. Signature and title of certifier   | C State   | -   | 29c. Licer                              | nse number                                 | 2   | 9d. Date signed (/                      | Month, Day, Year)   |  |
|                     | > - 0  |                   | Pota: Ona   | nica Pal  | 0.1   | 0                                       | .C.M.E                                     | i   |   | , 2005  |  |
|                     | 10   |                   | 30. Name and address of person who con  | mpleted cause of dear   |   |   |  |   |   |   |  |
|                     | 1  |                   |   | Nica-tolla  | T-V-  | N STREET                                | , BALTIMO                                  | ORE, MARYL  | AND 21201                               | L   |  |
|                     | Sta<br>Registr   |                   | 31. Date filed (Month, Day, Year)   | 32 Registrar's  | Signature   | ull)                                    |  |   |   |   |  |

ADH Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Unpend item#23a,27 pen/F.(351,1/1/06 III State of Maryland / Department of Health and Mental Hygiene 05 ROBERT ALONZO 1 - State Registrar 05-8493 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death DECEMBER 16, Physician 2005 LONZO 0800 OBERT /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner WICOMICO PENINSULA REGIONAL HOSPITAL SALISBURY If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Months Days Hours Min. (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1**⊘**M 2□ F 216-70-0899 Director 11-28-5 Usuel Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits or iteme 23a or 28e-f ehow the Medical Examiner must be notified at 1 Nes 2 □ No MD Director COMICS ALISBURL 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 80 1008 HUE by Funeral . Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after TRYes 2 No If Ves, Give Year or Dates: ARMY 1 Never Married 2 Married 1□Yes 2X No Baltimore, Maryland 21215-0036 Specify: Specify: BLACK 3 Widowed 4 Divorced "natural", Be Completed h6a. Decedent's Usual Decupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Pages 1 and 2 should be filed within nent of Heelth and Mental Hygiene. ant: if Item 27 is marked other than "ury or other traumetic event, Ita Ma Elementary/Secondary (0-12) College (1-4or 5+) ROOFER PENINSUL KOOFING 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) DRAYTON JACK 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ST. ApT 139 SAUSBURY DAUSBURN D 2180) 20c. Location - City I Town, State DRAYTON ~ MOTHER -GATEWAY ARRIET 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 Domation 5 Other (Specify) permit. Page Depertment of Important: if eny injury or once. EMETERY 112 21/05 HURL 21. Signature of Funeral Service Licensee BENNIE 22. Name and Address of Facility SMIT W. ISABELLA ST. SALISBURY 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betwe Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Hemopericardium due to dissection of the Aorta /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner signed by the ettending physicien and deedetached for use as the burial-transit or Attending Physician: The law requires thet the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Certification: To Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 23d. Date of delivery 3 DEctopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? cate has been sig , page 2 should b 21 No 1 Tyes 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No certificate 1 Yes 2 No To the Hospitel or Attending Physician: within 24 hours after death.

To the Funerel Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner?
1 XYes 2 No 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Inpatient 2X ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 🗌 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) OCME Marine Vone iw DECEMBER 17, 2005

State Registrar MARGARUM

31. Date filed (Month, Day, Year)

111 PENN STREET, BALTIMORE, MARYLAND, 21201

30. Name and address of person who completed cause of death (ftem 23a) (Type, Print)

32. Registrar's Signature

D. KORELL

DEC 1 9 2005

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygione For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician Daisy Lucille Abramson December 6, 2005 2:00 P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Sligo Creek Nursing & Rehab. Center Takoma Park Montgomery 8. Date of Birth (Month, Day, Year) 9. Birthplace (Science Country)

June 24, 1928 North Carolina If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 □ M 21 F 77 245-50-9868 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits oriant: If Itam 27 is marked other than "natural", or Itams 23a or 28a-1 show injury or other traumatic event, the Medical Examination must be notified at txTxYes 2 □ No Directo Maryland Prince George's Temple Hills 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 4320 23rd Place 20748 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 ☐ XNo If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 TNo þ Specify: Black 3 XWidowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Itam 27 is marked other than "any injury or other traumatic event, the Muonce. Elementary/Secondary (0-12) College (1-4or 5+) Registered Nurse Medicine 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be nent of Health and Mental Samuel McArthur Janie McLean 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Raepheal McArthur 4320 23rd Place, Temple Hills, MD (nephew) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 

Burial 2 

Cremation 3 

Removal from State \* 4 □Donation 5 □ Other (Specify) Lincoln Memorial 12/12/05 Suitland, Maryland 21. Signature of Funeral Service Licen 22. Name and Address of Facility McGuire Funeral Service 7400 Georgia Ave. N.W., Washington, D.C. 20012 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death mmediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medicai use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 Yes 2X No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 1 Yes 2 X No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Mursing Home 5 Residence 6 Other (Specify) 1 Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No hours after death. investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral D 29a. Certifier 🛣 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicai 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D46998 December 8, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Steven T. Tee, M.D. 3415 Hamilton St. Suite 1, Hyattsville, MD

Registrar

31. Date filed (Month, Day, Year)

DEC 0 9

2005

2. Registrar's Signature

| _                   |   |                | 1 - For<br>State<br>Registrar  | State of M                           | aryland /             |                       | artmen<br>tificate         |                    |                       | and M      |                                  | giene<br>Reg. No. | 05              | 415                             | 7 L         |
|---------------------|---|----------------|--|--------------------------------------|-----------------------|-----------------------|----------------------------|--------------------|-----------------------|------------|----------------------------------|-------------------|-----------------|---------------------------------|-------------|
|                     | Physici   | 22             | 1. Decedent's Name (First, Middle, Last)   |                                      |                       |                       |                            |                    |                       |            | 2. Date of Dea<br>Month          | ath<br>Day        | Year            | 3. Time o                       | of Death    |
|                     | Physici<br>/Medio   |                |  | h Isabel                             |                       | ts                    |                            |                    |                       |            | Decembe                          |                   | 2005            | 1630                            | РМ          |
| 7                   | Examin  | ner            | 4a. Facility Name (If not institution, give s                                    |                                      |                       |                       |                            |                    | Location o            | of Death   |                                  |                   | ounty of Deat   | h                               |             |
|                     |   |                | Laurelwood Care  |                                      |                       |                       |                            | kton               |                       | 0411       |                                  |                   | Cecil           |                                 |             |
|                     | Funeral   |                | 5. Social Security Number 6. Sex   | M 2071 E                             | je (In yrs. last<br>C | Yrs.                  | If Under<br>Months         | Days               | If Under a            | Min.       | 8. Date of Birt                  | y, Year)          | 9. Birt         | hptace (State untry)            | or Foreign  |
|                     | Director  |                | 212-18-1682  | M 287 8                              | 0                     |                       |                            |                    | ļ                     |            | DEC 13                           | , 191             | 9 M             | arylan                          | 1           |
|                     | land<br>ow  |                | 10a. State 10b. County   |                                      | 10c. City, T          | own or Lo             | cation                     |                    |                       |            |                                  |                   |                 | 10d. Inside (                   | City Limits |
|                     | Many<br>-f sh   | ţ              | Maryland Cecil   |                                      | E1k                   | ton                   |                            |                    |                       |            |                                  |                   |                 | 1 X Yes                         | 2 No        |
|                     | 1 the   | Directo        | 10e. Street and Number   |                                      | DIK                   | COII                  | 10f. Zip                   | Code               |                       |            | T                                | 10g. Citize       | n of What Co    | untry?                          |             |
|                     | 3a o  | Die            | 100 Laurel Drive   |                                      |                       |                       | 219                        | 221                |                       |            |                                  | Uni               | ted St          | ates                            |             |
|                     | deed and a  | Funerai        |  | 2. Was Decedent<br>Armed Forces?     | Ever in U.S.          | 13. V                 |                            |                    | spanic Orig           | gin? (Spe  | ecify Yes or No-<br>Rican, etc.) |                   | Race - Ame      | rican Indian,                   |             |
| 9                   | or ite  | E.             | 1 Never Married 2 Married  | 1 ☐ Yes 2 🕅                          |                       |                       | Tes, spec                  |                    | Specify:              | i, Puerto  | nican, etc.)                     |                   | Black, White    | 9, Otc.                         |             |
| 003                 | ural',  | d by           | 3 X Widowed 4 □ Divorced   | Year or Dates:                       |                       |                       | 1 1 1 6 3 2                | <b>X</b> (10       | Зреспу.               |            |                                  | 3,                | pecify: W       | hite                            |             |
| 2                   | "nat  | Completed      | 15. Decedent's Educ<br>(Specify only highest grade                               | ation<br>completed)                  | 1                     | (Give                 | lent's Usua<br>kind of wor | k done a           | luring most           | t of worki | ng                               | 16b. Kind         | of Business/    | Industry                        |             |
| 12                  | withir<br>sne.  | E D            | Elementary/Secondary (0-12)  | College (1-4or                       | 5+)                   |                       | DO NOT us                  |                    | ,                     |            |                                  | D                 |                 |                                 |             |
| d 2                 | filed within 72 hours after deeth with the Maryland<br>Hygiene<br>ther than "natural", or lieme 23a or 28e-f show<br>whit, the Modical Exactional be notified at  |                | 17. Father's Name (First, Middle, Last)  |                                      |                       | waı                   | tress                      | 5                  | 18. Mothe             | r's Name   | (First, Middle,                  |                   | staura          | nt                              |             |
| an                  | d be<br>ental   | To Be          | Peter Smith  |                                      |                       |                       |                            |                    |                       |            | abelle                           |                   |                 |                                 |             |
| Maryland 21215-0036 | 12 should be filed within "h and Mental Hygiene." I'ls marked other than "Ireumatic event, II e Men   | F              | 19a. Informant's Name/Relationship (Type   | oe, Print)                           |                       | 19b. Mailin           | a Address                  | (Street a          |                       |            | d Dette<br>Il Route Numbe        |                   | _               | in Code)                        |             |
| <b>S</b>            | ith ar<br>27 is   |                | Arlene Myers/Daugh   | ter                                  |                       |                       |                            |                    |                       |            | kton, M                          |                   |                 |                                 |             |
| ē,                  | s 1 and 2 should be filed within 72 hours after deeth with the Marylan of Health and Mental Hygiene. Item 27 is marked other than "natural", or Heme 23s or 28e-f show other treumatic event, if a Mydical Exp. of ter mat be notified at |                | 20a. Method of Disposition   |                                      | 20b. Place            | e of Dispos           | sition (Nam                | ne of              |                       |            |                                  | 20c, Loca         | tion - City or  | Town, State                     |             |
| Ë                   | 1 December Chesape (Appendix) 3 Removal from State Bethel Cemetery 19, 2005 Mary lar  |                |  |                                      |                       |                       |                            |                    |                       |            |                                  | clity,            |                 |                                 |             |
| Baltimore,          | mit.  |                | 21. Signature of Funeral Service License   | 0                                    |                       |                       |                            |                    | s of Facilit          | тэ,<br>Уп. | 1 - T                            | riai y            | Land            |                                 |             |
| m                   | Depa<br>Impo<br>any ir  |                | Donard &   | Hul                                  | 23                    | 1(                    | 13 W.                      | Sto                | ckton                 | Str        | rals, F<br>eet, El               | kton.             | . Marvl         | and 21                          | 921         |
|                     | - 9 (9)   |                | 23a. Part1. Enter the disease, or complice shock, or heart failure. List only on | cations that cause                   | d the death. [        |                       |                            |                    |                       |            |                                  |                   |                 | Approxima<br>Interval Be        | te          |
| 200                 | Physician   |                | Immediate Cause (Final disease or condition                                      |                                      |                       | And                   | 00                         | 7.0                | 0-                    |            |                                  |                   | 14              | Onset and                       |             |
| 1                   | /Medical  |                | resulting in death)  | Due to (or as                        | a consequen           | ice of):              | 7                          | שונס               |                       |            |                                  |                   | -               |                                 |             |
| Н                   | Examiner  |                | Sequentially list conditions, b  | my                                   | a consequen           | 五                     | efact                      | for                | _                     |            |                                  |                   |                 |                                 |             |
|                     | p tis   | Examiner       | if any, leading to immediate cause. Enter Underlying Cause (Disease or injury    | Due to (# as                         | a consequen           | ice of):              | 10                         | •                  |                       |            |                                  |                   |                 |                                 |             |
| <b>V</b>            | and<br>and<br>I-tran  | хаш            | that initiated events resulting in death) Last                                   | Due to (or as                        | a consequen           | ice of):              | Sim                        | بالضال             |                       |            |                                  | _                 |                 |                                 |             |
| 8760,               | be executed<br>sicien and<br>burial-transit   | a E            |  | Hen                                  | olas.                 | .00 01).              |                            |                    |                       |            |                                  |                   |                 |                                 |             |
| 687                 | ate<br>he   | edicai         |  | 13                                   | ICHEAU.               |                       | ,                          |                    |                       |            |                                  |                   |                 | _                               |             |
| Вох                 | death certific<br>attending pl  | Physician/Me   | IF FEMALE: 23b. Was decedent pregnant 23   | 3c. If yes, outcome                  | of pregnancy          |                       |                            |                    |                       |            |                                  | 230               | d. Date of deli | VAIV                            |             |
| -                   | death<br>e atte<br>d for  | ic.            | in the past 12 months?<br>1 ☐ Yes 2 No   | 1□Live birth<br>4□Pregnant a         |                       |                       | Ectopic pro<br>Other (spe  |                    |                       |            |                                  |                   | Month           |                                 | Year        |
| P.0.                | that the di<br>ed by the<br>detached  | hys            | 9 🗆 Unknown  | 9∐ Unknown                           |                       |                       |                            |                    |                       |            |                                  |                   |                 |                                 |             |
|                     | es tha<br>Igned<br>be de  |                | Part II. Other significant conditions con  | tributing to death t                 | out not resulting     | ng in the ur          | nderlying ca               | ause give          | n in Part I.          |            | 23e. Did to                      | bacco use         | contribute to   | the cause of                    | death?      |
| pic                 | w require<br>been sli<br>should t   | ted            | reliferal V  | duller                               | Officer               | <del>-</del>          |                            |                    |                       |            | 1 🗆 Y                            | ′es 2.⊡ో          | No 3⊟Pro        | obabiy 4 🗌                      | Unknown     |
| ecc                 | has be  | pie            |  |                                      |                       |                       |                            |                    |                       |            | 24a. Was<br>autop                | an i              | 24b. Were au    | topsy findings<br>completion of | available   |
| of Vital Records,   |   | Completed by   |  |                                      |                       |                       |                            |                    |                       |            | perfoi                           |                   | death?          | 2□ No                           |             |
| /ita                | Physicien: The this certificate ral director, pag   | Be             | 25. Was case referred to medical examiner?                                       |                                      |                       |                       |                            |                    |                       |            | (Check only o                    |                   |                 |                                 |             |
| of \                | di S  | မ              | TI THE ZIMMO   | ospital: 1  Inpati                   | - 1                   | /Outpatien            |                            |                    | 4 Nu                  |            | ne 5 Resid                       |                   |                 | city)                           |             |
| E                   | After<br>funer  | o              | 27. Manner of Death  1 Natural 5 ☐ Pending                                       | 28a. Date of Inju<br>(Month, Da      | y Year)               | Bb. Time of<br>Injury | M 2                        | 8c. Injury<br>Work | rat<br>⟨?<br>/es 2.∐1 |            | 28d. Describe h                  | now injury o      | ccurred         |                                 |             |
| Sic                 | death<br>tor: A   | ical           | 2 Accident investigation 3 ☐ Suicide 6 ☐ Could not be                            | 28e. Place of In                     | iury - At home        | a farm etre           |                            |                    | 183 2 1               |            | 28f. Location (S                 | Street and I      | Jumher or Ru    | ral Boute Nur                   | nher        |
| Division            | after<br>Dire   | Certification; | 4 Homicide determined  | building, e                          | ic. (Specify)         | , raini, 5ti          | oot, lactory               | , onle             |                       |            | City or Tow                      |                   | vomber or 710   | rai i route real                | 1001,       |
|                     | splte<br>sours<br>nerel   |                | 29a. Certifier 12 Certifying Phys  | icien: To the best                   | of my knowte          | dge, death            | occurred a                 | at the tim         | e, date and           | d place, a | and due to the                   | cause(s) ar       | nd manner as    | stated.                         |             |
|                     | To the Hospitel or Attending Ph<br>within 24 hours after death.<br>To the Funerel Dire, tor: After th<br>completely filled in b. the funeral  | Medical        | (Check only 2 Medical Exeminates)  | er: On the basis of<br>and manner st | of examination        | and/or inv            | estigation,                | in my op           | inion, deat           | th occurr  | ed at the time,                  | date and pl       | ace, and due    | to the cause(                   | s)          |
|                     | To the To the comp  | ž              | 29b. Signature and title of certifier  |                                      |                       |                       | 29c                        | License            | number                |            |                                  | 29d. Date s       | signed (Month   | n, Day, Year)                   |             |
|                     | ^   |                | In Eco Ns  | 40                                   |                       |                       | F                          | 20 66              | 323                   |            |                                  | 12/               | 19/00           | >                               |             |
|                     | 7   |                | 30. Name and address of person who co  |                                      | death (Item 23        | Ва) (Туре,            |                            |                    | noe                   | < 0        | A 10                             |                   | 111             | 192                             | 1           |
|                     |   |                |  | M M D                                | · ~ ~                 | 223                   | We                         | it                 | 71/06                 | 1 8        | su eu                            | ا سال             | Ma >            | 11/2                            | 1_          |
|                     | Sta<br>Regist   |                | 31. Date filed (Month, Day, Year)  | 1                                    | rar's Signature       | Book                  | well !                     |                    |                       |            |                                  |                   |                 |                                 |             |

|            |  |               | 1 - For<br>State<br>Ragistrar  | State of   | Marylan                       |                                  |                                |   | ealth a<br>Death           |  | lental Hyç                                 | giene<br>Reg. No.     | 005                      |                    | 41575  |
|------------|--|---------------|--|--|-------------------------------|----------------------------------|--------------------------------|---|----------------------------|--|--|-----------------------|--------------------------|--------------------|--|
|            | Dhusisi  |               | 1. Decedent's Name (First, Middle, La  | st)  |                               |                                  |                                |   |                            |  | 2. Date of Dea<br>Month                    |                       | V.                       | 205                | 3. Time of Death                               |
|            | Physici<br>/Medio  |               | Margaret M. B  | rew  |                               |                                  |                                |   |                            |  | Decembe                                    | er ľ                  | 200                      | 5                  | 11:30AM  |
|            | Examin   |               | 4a. Facility Name (If not institution, giv   | re street and numb                                     | ver)                          |                                  |                                |   | Location of                | of Death                                 |  |                       | County of I              |                    |  |
|            |  |               | 2003 Wooded Way  |  |                               |                                  |                                | lphi                                    |                            | 0411                                     |  | . 1                   |                          |                    | eorges   |
|            | Funeral<br>Director  |               | 5. Social Security Number 6. S   | oex<br>1□M 2ĂF /.                                      | Age (In yrs. 90               |                                  | Months                         | r 1 Year<br>Days                        | If Under<br>Hours          | Min.                                     | 8. Date of Birth<br>(Month, Day<br>May 24, | h<br>/, <i>Year</i> ) | 9.<br>M.                 | Cour               | lace (State or Foreign                         |
|            |  |               | Usual Residence of Decedent  |  | 90                            |                                  |                                |   |                            |  | May 24,                                    | 19.                   | L) M                     | ary.               | länd   |
|            | yiand<br>wow   |               | 10a. State 10b. County   |  |                               | y, Town or Lo                    | cation                         |   |                            |  |  |                       |                          | 1                  | 0d. Inside City Limits                         |
|            | Mar.   | tor           | Maryland Prince  | Georges  | A                             | delphi                           |                                |   |                            |  |  |                       |                          |                    | 1 ☐ Yes 2 No                                   |
|            | or 284   | Director      | 10e. Street and Number   |  |                               |                                  | 10f. Zi                        | Code                                    |                            |  |  | 10g. Citi:            | zen of Wha               | it Coun            | try?   |
|            | d within 72 hours after death with the Maryland<br>jene.<br>rr then "neturel", or items 23e or 28e-f ehow<br>fre Medical Evandar must be rediffed at | aiD           | 2003 Wooded Way  |  |                               |                                  | 2                              | 20783                                   |                            |  |  | US                    | SA                       |                    |  |
|            | ems<br>ems   | Funerai       | 11. Marital Status   | 12. Was Decede<br>Armed Force                          | ent Ever in U                 | .S. 13. \                        | Was Dece                       | dent of Hi                              | spanic Ori                 | gin? (Spe                                | cify Yes or No-<br>Rican, etc.)            |                       | 14. Race - A<br>Black, V |                    |  |
| 36         | or it  |               | 1 Never Married 2 Married  | 1 Tes 2  | No No                         |                                  | 1 ☐ Yes                        |   | Specify:                   | ,, | 110411, 010.,                              |                       | Specify:                 |                    |  |
| 8          | urel',   | d by          | 3 ☐∰Widowed 4 ☐ Divorced   | Year or Date   | 9S:                           |                                  |                                |   |                            |  |  |                       |                          | WI                 | nite   |
| 21215-0036 | - 2 -  | Completed     | 15. Decedent's E<br>(Specify only highest gra  |  |                               | 16a. Deced                       | kind of wo                     | al Occupa<br>ork done d<br>ise retired) | uring mos                  | t of worki                               | ng   | 16b. Kir              | nd of Busin              | ess/Ind            | lustry   |
| 7          | within<br>ene.<br>then "   | шc            | Elementary/Secondary (0-12)  | College (1-4   | or 5+)                        |                                  | e Mak                          |   |                            |  |  | Or                    | vn Hor                   | m <sub>G</sub>     |  |
| 0          | E F E  |               | 17. Father's Name (First, Middle, Last   | ·)   |                               | HOM                              | c Har                          |   | 18. Mothe                  | r's Name                                 | (First, Middle,                            |                       |                          | 116                |  |
| Maryland   | should be<br>nd Mental<br>marked o   | To Be         | Antonio Miceli   |  |                               |                                  |                                |   |                            |  | riganti                                    |                       |                          |                    |  |
| Mar        | alth and 25 th   |               | 19a. Informant's Name/Relationship ( George Brew - So  |  |                               |                                  |                                |   |                            |  | A Route Numberille MD                      |                       |                          | te, Zip            | Code)  |
| Baltimore, | permit. Pages 1 and 2 should be Department of Health and Menta Importent: If Item 27 ie marked any injury or other treumatic en once.                |               | 20a. Method of Disposition 1 🔀 Burial 2 🗆 Cremation 3  |  | ate C                         | lace of Dispo                    | natory or o                    | other place                             | 1                          |  | ate  |                       | cation - City            |                    |  |
| Ē          | artme<br>arteni<br>orteni<br>njury   | - 14          | <ul> <li>4 □ Donation 5 □ Other (Special</li> <li>21. Signature of Funeral Service Lices</li> </ul>                              |  | FO                            | rt Line                          |                                |   |                            |  | 0/2005<br>mes-Rina                         |                       | entwoo                   |                    |  |
| Ba         | Depire<br>Impo   |               | Muse 1 1/0x  | A  |                               |                                  |                                |   |                            |  |  |                       |                          |                    | поше<br>g MD 20904                             |
|            |  |               | 23a. Part1. Enter the disease, or com  | plications that cau                                    | sed the deat                  |                                  |                                |   |                            |  |  |                       | op.                      |                    | Approximate                                    |
|            | Physician  |               | Immediate Cause (Final disease or condition  | one cause on eac                                       | ine.                          | Artery                           |                                |   |                            |  |  | ,                     |                          |                    | Interval Between<br>Onset and Death<br>Years   |
|            | /Medical<br>Examiner   |               | resulting in death)  |  | as a conseq                   |                                  |                                |   |                            |  |  |                       |                          | -                  |  |
| В          |  | _             | Sequentially list conditions,  | D  | eroscl<br>as a conseq         | erosis                           |                                |   |                            |  |  |                       |                          |                    | Years  |
|            | ted<br>nsit  | Examine       | Sequentially list conditions, if any, leading to immediate cause. Enact theorying Cause (Disease or injury that initiated events |  | 355                           | scular                           | Dice                           | 2200                                    |                            |  |  |                       |                          | 1.                 | V  |
|            | ficate be executed physician and sthe burial-transit   | хаг           | that initiated events<br>resulting in death) Last  | C  | as a conseq                   |                                  | D 1.00                         |   |                            |  |  |                       |                          |                    | Years  |
| 8760,      | siciar<br>siciar<br>b buri   | dicai E       | T. T.  | 4  |                               |                                  |                                |   |                            |  |  |                       |                          |                    |  |
| .89        | ificati<br>g phy<br>as the   | 0             |  | _ u,   | -                             |                                  |                                |   |                            |  |  |                       |                          |                    |  |
| Box        | death certifii<br>e attending f<br>id for use as   | Physician/M   | IF FEMALE:<br>23b. Was decedent pregnant   | 23c. If yes, outco                                     |                               |                                  | -                              |   |                            |  |  | 2                     | 3d. Date of              | delive             | ry   |
|            | 0 0  | icia          | in the past 12 months?<br>1 ☐ Yes 2 ☑ No   | 4 Pregnan  | h 2 🗌 Feta<br>It at time of d |                                  | lEctopic p<br>Other <i>(s)</i> |   |                            |  |  |                       | Month                    |                    | Day Year                                       |
| P.0        | at the de<br>by the a<br>tached t  | hys           | 9 Unknown  | 9□ Unknow  | n                             |                                  |                                |   |                            |  |  |                       |                          |                    |  |
| Ś          | igned<br>be de   | by            | Part II. Other significant conditions of Hypertensi  |  | th but not res                | ulting in the ur                 | ndertying o                    | ause give                               | n in Part I.               |  |  |                       |                          |                    | e cause of death?                              |
| COL        | > 0 0  | lete          |  |  |                               |                                  |                                |   |                            |  |  |                       |                          |                    |  |
| Record     | The law<br>ate has b<br>page 2 sł  | Completed     |  |  |                               |                                  |                                |   |                            |  | 24a. Was a autops perfor                   | sy<br>med?            | prior<br>deat            | to con             | osy findings available<br>apletion of cause of |
| Viita      | en: T  |               | 25. Was case referred to medical   |  |                               |                                  |                                |   | OC Disease                 | of Dooth                                 | 1 ☐ Yes :                                  | 2℃ No                 | 10                       | Yes                | 2 No   |
|            | Physicien:<br>this certific<br>ral director,   | o Be          | examiner?<br>1 □ Yes 2 □¥No  | Hospital: 1 □ Inp                                      | atient 2 🗆                    | ER/Outpatien                     | t 3 🗆 D                        | Othe                                    |                            |  | ne 5 AReside                               |                       | □Other /9                | Spacific           | 1::  |
| J Of       |  | L i           | 27. Manner of Death  | 28a. Date of   |                               | 28b. Time of                     |                                | 28c. Injury<br>Work                     | at                         |  | 8d. Describe h                             |                       |                          | эроспу             | /  |
| 0          | Attending r death. ector: After by the fune  | atlo          | 1 Accident 5 Pending 2 Accident investigation  | n  | Day rear,                     | Injury                           | М                              |   | es 2 🗆 l                   | Vo                                       |  |                       |                          |                    |  |
| Division   | r Atte   | ertification: | 3 Suicide 6 Could not b  | Zoe. Flace of  | Injury - At ho                | ome, farm, stre                  | et, factor                     | y, office                               |                            | 2  | 28f. Location (Si<br>City or Town          | treet and             | Number o                 | r Rural            | Route Number,                                  |
|            | itel or<br>ret Dir<br>lled in  | O             |  |  |                               |                                  |                                |   |                            |  |  |                       |                          |                    |  |
|            | To the Hospitel or Attend within 24 hours after death To the Funerel Director: / completely filled in by the f                                       | edical        | 29a. Certifier 1 Certifying Ph<br>(Check only one) 2 Medical Example   | nysician: To the be<br>minar: On the basi<br>and manne | is of examina                 | wledge, death<br>tion and/or inv | occurred<br>restigation        | at the time<br>, in my op               | e, date and<br>inion, deat | d place, a                               | and due to the c<br>ad at the time, d      | ause(s) a<br>ate and  | and manne<br>place, and  | r as sta<br>due to | ated.<br>the cause(s)                          |
|            | To the within 2. To the Complet  | Me            | 29b. Signature and title of certifier  |  |                               | 1                                |                                | c. License                              |                            |  |  | 9d. Date              | signed (M                | Ionth, L           | Day, Year)                                     |
|            | ,  |               | 4 Du   | id   | 7                             |                                  | D                              | 28                                      | 92                         | 01                                       | to ylad                                    |                       |                          |                    |  |
| 1          | V  |               | 30. Name and address of person who   | completed cause  | of death (Item                | 23a) (Type,                      | Print)                         |   |                            |  |  |                       |                          |                    |  |
|            |  |               | Surinder Singh M   |  |                               |                                  |                                |   | 118 S                      | Silve                                    | r Sprin                                    | g MI                  | 2090                     | )2                 |  |
|            | Sta<br>Registr   | _             | 31. Date filed (Month, Day, Year) DEC 0 9  | 2005 32. Reg   | istrar's Signa                | iture                            | sell                           | 1                                       |                            |  |  |                       |                          |                    |  |

State of Maryland / Department of Health and Mental Hygiene 05 Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Day Year **Physician** Dec. 8, C. W. BERRY 2005 7:45A /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 6412 Greig Street #102 Seat Pleasant P.G. If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Min 1**⊈**M 2□F 70 Yrs. Director 9-29-35 247-52-7989 S.C Usual Residence of Decedent with the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show 27 is marked other than "natural", or Items 23a or 28a-f shor traumatic event, the Medical Examinar must be notified at Yes 2 No Completed by Funeral Director MD. Prince Georges Seat Pleasant 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6412 Greig Street 20743 U.S.A. Pages 1 and 2 should be filed within 72 hours after death inent of Health and Mental Hygiene. Int If Item 27 is marked other than "natural", or Items 23 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: Black 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b, Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Cook Private 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pail Berry Emma Avery 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lois Gray/Niece 912 Minna Ave. Capitol Hgts. Md. 20743 d'or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Department of Important: If any Injury or once. 12/17/05 Suitland, Md. Lincoln Mem. Cem. 22. Name and Address of Facility
Hackett's Funeral Chapel, Inc. 21. Signatur, Funeral Service Licensee Part. Elter the disease, or complications that cause 1' e death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. LA Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of injury Due to (or as a consequence of) Examiner The law requires that the death certificate be executed anding physician and use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Year 4 Pregnant at time of death 5 Other (specify) P.0. 9 Unknown sate has been signed I page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco us contribute to the cause of death? þ Records, 3 Probably 4 Unknown 1 🗌 Yes No Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2□ No 1 Yes No No 1 Yes Division of Vital Hospital or Attending Physician: director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) 2 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Natural 2 Accident 5 Pending death. 1 ☐ Yes 2 ☐ No investigation within 24 hours after deat To the Funeral Director: 6 Could not be determined 3 T Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) þ 4 T Homicide Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mainly as stated.

2 Medicel Exeminen On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only 29b. Signature and title of 29d. Date signed (Month, Day, Year) Dec. 8, 2005 3 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Elwood S. Holland, 6005 Landover Rd M.D. S-3 Cheverly, Md. 20785 31. Date filed (Month, Day, Year) 32. Registrar's Signature **DEC 09** 2005 Registrar

Amended Item 23a Part I, Line b per Physician 12/07/2005 Carroll County, wj1 Amended Items 1, 4c, 23e, 30 per Physician 12/06/2005 Carroll County, wj1 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Month 3. Time of Death 1. Decedent's Name (First, Middle, Last) RoseMary Bryant Day Year **Physician** December 2001 12:020 M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Rendell Dur Horbital Northwest Baltimor II Under 1 Year II Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace Country) **Funeral** Days 214-24-7681 77 Director July 24, 1928 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other then "neturel", or items 23e or 28e-f show any injury or other treumatic event, the Medical Examiner must be notified at once. 1 Yes 2 No Directo Maryland Baltimore Woodstock 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21163 United States 10822 Davis Ave. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status within 72 hours after 1 ☐ Yes 2 🕱 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☑ No White Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Coltege (1-4or 5+) 2 Homemaker own home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Martha Rose Brantley Edward Joseph Dennis 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 10822 Davis Ave. Woodstock, MD 21163 James E. Bryant, Sr. Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 N Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lake View Mem. Park | Dec. 8, 2005 Sykesville, MD 22. Name and Address of Facility
Burrier-Queen Funeral Home & Crematory, 21. Signature of Funeral Service Licensee 1212 W. Old Liberty Road Winfield, Md 21784 234. Party. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition esulting in death) Failure Reyirdon **Physician** /Medical Due to (or as a consequence of): Examiner Arteriosclerotic Cardiovascular Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine To the Hospitel or Attending Physicien: The law requires thet the death certificate be executed physicion and sthe burial-transit Due to (or as a consequence of) Records, P.O. Box 68760 Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 9 Unknown 23d. Date of delivery 3 Ectopic pregnancy Day Month Year 4☐Pregnant at time of death 5 Other (specify) ed by the detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 2 No 1 Yes 2 No Division of Vital Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဥ 1 ☐ Yes 2 No 1 patient 2 ER/Outpatient 3 DOA After the 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1. Natural 5 Pending investigation М 1 ☐ Yes 2 ☐ No I Director: A 2 Accident 6 ☐ Could not be determined 3 🗌 Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, larm, street, lactory, office building, etc. (Specify) within 24 hours after or To the Funeral Direct completely filled in by filled in by 4 Homicide Possibility Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier MIL 000 56430 2005 December 2 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rodney Biglow, M.D., Northwest Hospital Ctr. Randallitow

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

ORIGINAL

32. Registrar's Signature

2005

|            |   | 4              | For<br>Stata<br>Registrar   |                                | State of                                 |                            | nd / Depa             |                                | of He               | ealth a             |                       | -                             | gien            | UUU                        | 41578                           |     |
|------------|---|----------------|---|--------------------------------|--|----------------------------|-----------------------|--------------------------------|---------------------|---------------------|-----------------------|-------------------------------|-----------------|----------------------------|---------------------------------|-----|
|            |   |                | Decedent's Name (Fit  | rst, Middle, L                 | ast)                                     |                            |                       | imodio                         |                     | - Catiri            | 1                     | 2. Date of D                  | Reg. No<br>eath | 0.                         | 3. Time of Death                | 1   |
|            | Physici   |                | Louise  | A                              | Beres                                    |                            |                       |                                |                     |                     |                       | Month 1/2                     | Da              | 05 C                       | -IOII-A                         | M   |
|            | /Medic<br>Examin  |                | 4a. Facility Name (If not   |                                |  | er)                        |                       | 4b. City, To                   | wn, or l            | Location o          | f Death               | V                             | 40              | c. County of De            | -                               |     |
|            |   |                | ANNE ARUNDI   | EL MED                         | ICAL CENT                                | ER                         |                       | ANNAP                          | OLI                 | S                   |                       |                               | Al              | NNE ARU                    | NDEL                            |     |
|            | Funeral   |                | 5. Social Security Numb   | er 6.                          |  |                            | last birthday)        | If Under 1 \ Months E          | Year<br>Days        | If Under 2<br>Hours | 24 Hrs.<br>Min.       | 8. Date of B<br>(Month, D     |                 |                            | irthplace (State or Forei       | ign |
|            | Director  |                | 162 20 5203<br>Usual Residence of Dec   |                                | X.                                       | 83                         | 3 Yrs.                |                                |                     |                     |                       | NOV.20                        | 0 <b>,</b> 19:  | 23 PE                      | NNSYLVA NIA                     |     |
|            | ow ow   |                |   | o. County                      |  | 10c. Cit                   | ty, Town or Lo        | cation                         |                     |                     |                       |                               |                 |                            | 10d. Inside City Limi           | its |
|            | Mary<br>f sh  | ţō             | MARYLAND A  | NNE AF                         | NDET.                                    | ANN                        | APOLIS                |                                |                     |                     |                       |                               |                 |                            | 1 X Yes 2□N                     | No  |
|            | or 280  | Director       | 10e. Street and Number  |                                | ЮПОДД                                    | 11111                      | CH OLLD               | 10f. Zip Co                    | ode                 |                     |                       |                               | 10g. C          | itizen of What (           | Country?                        |     |
|            | 23e   |                | 701 GLENWOO   | D STRE                         | ET #605                                  |                            |                       | 21401                          | 1                   |                     |                       |                               | UNI             | TED STA                    | ATES                            |     |
|            | er deg  | Funerai        | 11. Marital Status  |                                | 12. Was Deced<br>Armed Forc              | es?                        | .S. 13.               | Was Deceden<br>If Yes, specify | t of His<br>Cuban   | panic Orig          | gin? (Spe<br>, Puerto | cify Yes or N<br>Rican, etc.) | 0-              | 14. Race - An<br>Black, Wh | nerican Indian,<br>nite, etc.   |     |
| 36         | rs aft  | by F           | 1 ☐ Never Married 3€ Widowed 4 ☐  |                                | 1 XYes 2<br>If Yes, Give<br>Year or Date |                            | 3-45                  | 1 ☐ Yes 💥                      | □ No                | Specify:            |                       |                               | 1               | Specify: TATE              | HITE                            |     |
| 21215-0036 | be filed within 72 hours after death with the Maryland ital Hygiene. d other than "neturel", or items 23e or 28e-f show event. The Medical Examinat must be notified at | ted            | 15.   | Decedent's                     | Education                                | ~ 1J <del>4</del> .        | 16a. Dece             | dent's Usual C                 | Occupat             | tion                |                       |                               | 16b. h          | Kind of Busines            |                                 |     |
| 215        | hin 7.<br>B.<br>Bn "n<br>Medi   | Completed      | (Specify of   | -                              | rade completed) College (1-4             | or 5+)                     | (Give                 | kind of work of<br>DO NOT use  | done du<br>retired) | uring most          | of worki              | ng                            |                 |                            | •                               |     |
|            | filed wil<br>Hygien<br>other th   | Con            | 12  |                                | 1  |                            | HOMEM                 | AKER                           |                     |                     |                       |                               | HOM             |                            |                                 |     |
| nd         | tal Hydroth   | Be             | 17. Father's Name (First  | t, Middle, Las                 | st)                                      |                            |                       |                                |                     | 18. Mothe           | r's Name              | (First, Middle                | e, Maidei       | n Sumame)                  |                                 |     |
| Z          | should be<br>nd Menta<br>marked<br>imatic ev  | ဥ              | ARTHUR BENS   |                                | (Time Driet)                             |                            | 105 11-16             |                                |                     | OLA                 |                       |                               |                 |                            | 7.011                           |     |
| Maryland   | d 2 sh<br>th and<br>th and<br>7 Is m<br>treum   |                | 19a. Informant's Name/  |                                |  |                            |                       |                                |                     |                     |                       |                               |                 | or Town, State,            |                                 |     |
|            | ges 1 and 2 should<br>it of Health and Men<br>If item 27 Is marke<br>or other treumatic   |                | JUDY A. HAW<br>20a. Method of Disposit  |                                | (DAUGHTE                                 | 20b. F                     | Place of Dispo        |                                | of                  |                     |                       | 5 AIVIV                       |                 | JIS MD.                    |                                 | _   |
| JUO        | Pages<br>nent of<br>ent: If it  |                | 1 ☐ Burial 2 💢Cr<br>`4 ☐ Donation 5 ☐   |                                |  | ate                        | cemetery, crei        |                                | •                   | 1                   | 2 (                   | ٥٦                            | TIDO            |                            | MO                              |     |
| Baltimore, | - E # = .   |                | 21. Signature of Funera   |                                | riseo.                                   | I KA                       |                       | EMATORY  2. Name and A         |                     | of Facilit          | 2-6-                  |                               |                 | EWATER,                    |                                 |     |
| m          | Dermi<br>Depa<br>Impo<br>any ir   |                | 126   |                                | cla                                      | 2                          | 2                     | 973 SOI                        |                     |                     |                       |                               |                 |                            | RAL HOME<br>R.MD. 21037         |     |
|            |   |                | 23a. Part1. Enter the di<br>shock, or heart fai   | isease, or co<br>lure. List on | mplications that cau                     | sed the deat               |                       |                                |                     |                     |                       |                               |                 | CDWITTE                    | Approximate<br>Interval Between |     |
|            | Physician   |                | Immediate Cause (Fina disease or condition  | ul                             |  | Cerebr                     | al Va                 | scular                         | (                   | Recal               | der                   | t                             |                 |                            | Onset and Death                 |     |
|            | /Medical<br>Examiner  |                | resulting in death)   |                                | Due to (or                               | as a conseq                | uence of):            |                                | <i>\</i>            |                     |                       | ,                             |                 |                            | 1                               |     |
| ŀ.         | LAGITITICI  | 10             | Sequentially list condition   | ons,                           | b. Due to /or                            | as a conseq                | ferem                 | IR                             |                     |                     |                       |                               |                 |                            | Taays                           |     |
|            | ted<br>nsit   | Examine        | Sequentially list condition if any, leading to immediate. Enter Underlyin Cause (Disease or injur | g<br>y                         | Due 10 (01                               | as a conseq                | . 0                   | enal.                          | Kn                  | .0,                 |                       |                               |                 |                            | = olan                          | C   |
| Ć.         | be executed<br>sician and<br>burial-transit   | Exal           | that initiated events<br>resulting in death) Last   |                                | Due to (or                               | as a conseq                |                       | 1                              | p cu                |                     |                       |                               |                 |                            | souge                           |     |
| 8760,      | cate be executed<br>obysician and<br>the burial-transit   | icai           |   |                                | d  | Cono                       | restive               | Hea                            | it                  | Fai                 | lus                   | 2                             |                 |                            | 7day                            | S   |
| 9          |   |                | IE ECNANI E.  |                                | 32                                       |                            |                       |                                |                     |                     |                       |                               |                 |                            |                                 |     |
| Вох        | law requires that the death certifica<br>as been signed by the attending ph<br>2 should be detached for use as th   | Physician/Med  | IF FEMALE:<br>23b. Was decedent pre<br>in the past 12 mg/   |                                | 23c. If yes, outco                       | me of pregna<br>h 2 🗌 Feta |                       | Ectopic pregi                  | nancy               |                     |                       |                               |                 | 23d. Date of d             |                                 |     |
|            | the all   | /sici          | 1 Yes 2 No  |                                | 4∏Pregnar<br>9∏Unknow                    | nt at time of d            | death 5               | Other (speci                   | rfy)                |                     |                       |                               | i               | Month                      | Day Year                        |     |
| P.0        | that the dead by the detached   |                | Part II. Other significan   | t conditions                   | contributing to dea                      | th but not res             | sulting in the a      | nderlying caus                 | se nivei            | n in Part I         |                       | 23e. Did                      | tobacco         | use contribute             | to the cause of death?          |     |
| Records,   | uires tha<br>signed I<br>Id be det  | d by           | 77  | abete                          | 5 Mell                                   |                            |                       | ,                              | g                   |                     |                       |                               |                 | _                          | Probably 4 Unknov               | wn  |
| COL        | w raquir<br>been si<br>should   | lete           | H   | 21001                          | long                                     |                            |                       |                                |                     |                     |                       | 24a. Wa                       | s an            | 24b. Were                  | autopsy findings availab        | nle |
| Re         | The his age   | ompleted       | Ollia   | gial                           | at Co                                    | 111000                     | ascula                | Drs                            |                     | 0                   |                       | perl                          | opsy<br>ormed?  | prior to<br>death?         | completion of cause o           | if  |
| Vital      | iclen: T  | C              | 25. Was case referred t   | to medical                     | Sieuc Ca                                 | MONOY                      | muca                  | 1 013                          |                     |                     | of Death              | 1 Yes                         | 2 TN            | o 1□Y€                     | es 2 No                         |     |
| of V       | S S   | To B           | examiner?<br>1 Tes 2 No   |                                | Hospital: 1 Hing                         | patient 2                  | ER/Outpatier          | nt 3 DOA                       | Other               | r: 4 🗆 Nu           | rsing Ho              | ne 5 Res                      | idence          | 6 □Other (Sp               | ecify)                          |     |
| ח          | ding Phy<br>h.<br>After this<br>tuneral o   | on;            | 27. Manner of Death  1 PNatural 5   | Pending                        | 28a. Date of (Month,                     | Injury<br><i>Day Year)</i> | 28b. Time o<br>Injury |                                | . Injury<br>Work    | at<br>?             |                       | 28d. Describe                 |                 |                            |                                 |     |
| Sio        | 5 2 3 9   | icat           | 2 Accident 3 Suicide 6  | investigat Could not           | ho -                                     | f Imirrar At In            |                       | М                              |                     | es 2 🗌 i            | -                     | 204 Ltion                     | /04             |                            |                                 |     |
| Division   | of or Attendate after death Director:   | Certification; | 4 Homicide  | determine                      | building                                 | , etc. (Specif             | ome, farm, str<br>fy) | eet, factory, o                | MICO                |                     |                       | City or To                    |                 |                            | Rural Route Number,             |     |
|            | To the Hospitel or Atter<br>within 24 hours after de<br>To the Funerel Directo<br>completely tilled in by th  |                | 29a. Certifier 1  | Certifying                     | Physician: To the b                      | est of my kno              | owledge, deat         | h occurred at t                | the time            | e, date an          | d place, a            | and due to the                | e cause(s       | s) and manner a            | as stated.                      |     |
|            | the Horin 24 h  | edicai         | (Check only 2 one)  | Medical Ex                     | aminer: On the bas<br>and manne          | is of examina              | ation and/or in       | vestigation, in                | my opi              | inion, deat         | th occurr             | ed at the time                | , date an       | nd place, and du           | ue to the cause(s)              |     |
|            | To the within To the Comp   | M              | 29b. Signature and title  | of certifier                   |  |                            |                       | 29c. L                         | icense              | number              |                       |                               |                 | ate signed (Moi            |                                 |     |
| )          |   |                | 1   | X                              |  |                            | >                     |                                | DO                  | 0415                | 34                    |                               | 1               | 2/05/                      | 2005                            |     |
|            |   |                | 30. Name and address  | of person wh                   | o completed cause                        | of death (Iter             | т 23а) (Туре,         | Print) Kel                     | Lley                |                     |                       | n, M.D                        | •               | . ( a )                    |                                 |     |
|            |   |                | 31. Date filed (Month, D  | MCU(                           | y parky                                  | jistra 's Signa            | DU.                   | He 50                          | X)                  | Ann                 | apoli                 | 5 MD                          | d               | 401                        |                                 |     |
|            | Sta<br>Registi  |                |   |                                |  | Jistia s Signa             | and a                 | and .                          |                     |                     | 1                     |                               |                 |                            |                                 |     |
|            |   |                | UEU   | 0 8 20                         | U) K                                     | 10 D                       |                       | and the second                 |                     |                     | _                     |                               |                 |                            |                                 |     |

|  |           | For Amend Items 25 per verb.  Registrar   | Good TZ                                | tificate of D                                     | eath                                   |   | eg. No. UUJ                             | 41579   |
|--|-----------|---|--|---|--|---|---|---|
| Physician  | _         | I. Decedent's Name <i>(First, Middle, Last)</i> VIRGINIA BROWN  |  |   |  | 2. Date of Dea<br>Month                     | Day Ye                                  | 3. Time of Death  |
| /Medical<br>Examiner   |           | ta. Facility Name (If not institution, give street and number)  |  | 4b. City, Town, or Lo                             | ocation of Death                       | DECEMBER                                    | 2, 2005<br>4c. County of 0              | 8:20P M   |
| LXammer  | i         | 814 DALE STREET   |  | HAGERSTO  |  |   | WASHI                                   |   |
| uneral<br>rector   |           | 5. Social Security Number 6. Sex 1 M 2007 81  | s. last birthday)<br>Yrs.              |   | f Under 24 Hrs.<br>Hours Min.          | 8. Date of Birth<br>(Month, Day)<br>12/11/1 | Year) 9.                                | Birthplace (State or Foreign<br>Country)<br>VEST VIRGINIA |
|  | -         | Jsual Residence of Decedent  10a. State 10b. County 10c. 6  | Sib. Town and a                        |   |  | 12/11/1                                     | 720                                     |   |
| fledat   |           | MD WASHINGTON 10c. (  | City, Town or Lo<br>HAGERS             |   |  |   |   | 10d. Inside City Limits  XXYes 2 □ No                     |
| importent: It ten z / is marked order their institute; or items zay or zee-i show any highly or other treumatic event, the Medical Examinar must be multiped at once.  To Be Completed by Funeral Director   | 3         | 0e. Street and Number   |  | 10f. Zip Code                                     |  | 1   | 0g. Citizen of Wha                      | •   |
| eral   | 5         | 119 CLARKSON AVENUE  11. Marital Status  12. Was Decedent Ever in   | 115 13 1                               | 21 Was Decedent of Hisp                           | 740                                    | acity Yes or No-                            | 14 Bace -                               | USA<br>American Indian,                                   |
| by Fun   | 2         | Armed Forces?  1 ☐ Never Married 2 ☐ Married  1 ☐ Yes, Give Year, or Dates:   | t                                      | f Yes, specify Cuban,                             | Mexican, Puerto<br>Specify:            | Rican, etc.)                                |   | White, etc.  BLACK  |
| eted   |           | 15. Decedent's Education<br>(Specify only highest grade completed)  | (Give                                  | dent's Usual Occupation                           | on<br>ing most of worki                |   | 16b. Kind of Busin<br>LETTERKEI         |   |
| t, the Medical I   | 2         | Elementary/Secondary (0-12) College (1-4or 5+)  | PACI                                   | OO NOT use retired)                               |  |   | DEPOT                                   | MI ARH  |
| event,<br>Be C   | 3         | 17. Father's Name (First, Middle, Last)   |  | 18  |  |   | Maiden Sumame)                          |   |
| To   |           | CHARLES FRANK STANTON  19a. Informant's Name/Relationship (Type, Print)   | 19b. Mailin                            | g Address (Street and                             |  | IE STRI                                     |   | te Zin Code)  |
| any injury or other treumatic event, the Me<br>pnce.<br>To Be Compl  |           | WANDA BALTIMORE/DAUGHTER  |  | DALE STREE  |  |   |   | 10, 2,6 0000)   |
| or oth   | 1         | X Burial 2 Cremation 3 Removal from State   |  | natory or other place)                            | DEC.                                   | 9,  | 20c. Location - City                    |   |
| injury<br>ei   | -         | *4 Donation 5 Other (Specify)   | ERSTOWN (                              |   |  |   | RIPPON,                                 | , WV  |
| any it   |           | Chaelione Brown   | B                                      | ROWN FUNER<br>327 W. KING                         | AL HOME,<br>ST., MARTI                 | P.O. B<br>INSBURG, W                        | OX 821,<br>N 25402                      |   |
| for use as the burial-transit and proceed to the purial-transit and proceed to the process of th |           | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consider the conditions).  Due to (or as a consider the conditions).  Due to (or as a consider the conditions).   | equence of).                           |   |  |   |   |   |
| lysl   |           | IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1 ☐ Yes ☐ No 9 ☐ Unknown  23c. If yes, outcome of pregnant at time or one of the or one o | tal death 3                            | Ectopic pregnancy Other (specify)                 |  |   | 23d. Date of<br>Month                   | delivery<br>Day Year                                      |
| be o   | 2         | Part II. Other significant conditions contributing to death but not re  | esulting in the ur                     | nderlying cause given                             | in Part I.                             | 23e. Did tol                                |   | te to the cause of death?  Probably 4 □Unknown            |
| page 2 should be Completed   | and in on |   |  |   |  | 24a. Was a autops perform                   | v prior                                 |   |
| led in by the funeral director, pag<br>Certification: To Be Col  | 2         | 27. Manner of Leath Natural 5 Pending (Month, Day Year) 2 Accident investigation  | ER/Outpatien<br>28b. Time of<br>Injury | t 3 DOA Other:<br>28c. Injury at<br>Work?         | 6. Place of Death 4 Nursing Hor t 2 No | me Kuside                                   | ence 6X10ther (                         | Specify Daughter's<br>Residence                           |
| ed in by   |           | 3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury · At building, etc. (Spe   | home, farm, stre<br>cify)              | eet, factory, office                              | :                                      | 28f. Location (St<br>City or Town           | reet and Number on, State)              | r Rural Route Number,                                     |
| completely filled in by the fu   |           | 29a. Certifier (Check only one)  Certifying Physician: To the best of my k  | nowledge, death<br>nation and/or inv   | occurred at the time,<br>restigation, in my opini | date and place, a<br>ion, death occurr | and due to the ca<br>ed at the time, da     | ause(s) and manne<br>ate and place, and | r as stated.<br>due to the cause(s)                       |
| сотрі  | -         | 29b. Signature and title of certifier   | Lai                                    | 29c. License n                                    | umber<br>LL M                          | 3   | 9d. Date signed (M                      | Ionth, Day, Year)   |
| 1  | 1         | 39. Name and address of person who completed cause of death (It   | am 23a) (Type                          | Print)  | 0 7                                    |   | 10                                      | 111   |
|  |           | Hind Houndar  | ~ mc                                   | ): 113.   | 6 0                                    | PAL   | CT.                                     | Hagento   |

|   |   |                            | 1 - For<br>State<br>Registrar   |  | laryland / De          |                  | nt of H             | lealth and                  | Mental Hy                             |                | 05                  | 41580  |
|---|---|----------------------------|---|--|------------------------|------------------|---------------------|-----------------------------|---------------------------------------|----------------|---------------------|--|
| ,   |   |                            | 1. Decedent's Name (First, Midd   |  |                        |                  |                     |                             | 2. Date of De                         | ath            | Vone                | 3. Time of Death                                   |
|   | hysicia<br>/Medic                                       |                            | CHARLOTTE I   | REGINA CHII                            | LDS                    |                  |                     |                             | DEC.                                  | 9 Day 20       | 005 <sup>Year</sup> | 2:30 A <sup>M</sup>                                |
|   | xamin   |                            | 4a. Facility Name (If not institution   |  | )                      | 4b. City,        | Town, or            | Location of Dea             | ıth                                   |                | unty of Death       |  |
|   |   |                            | KLINE HOSPI   | CE HOUSE                               |                        |                  |                     | AIRY                        |                                       | FRE            | EDERI               | CK   |
|   | neral   |                            | 5. Social Security Number   | 6. Sex 7. A                            | ge (In yrs. last birth | Months           | r 1 Year<br>Days    | If Under 24 Hr<br>Hours Mir |                                       | th<br>y, Year) | 9. Birth            | place (State or Foreign intry)                     |
| Dir   | ector   |                            | 220-34-2890 Usual Residence of Decedent   |  | 86 Yr                  | s.               |                     |                             | FEB 1                                 | 4 19           | 19                  | MD   |
| land  | A ==  |                            | 10a. State 10b. Count   | у                                      | 10c. City, Town        | or Location      |                     |                             |                                       |                |                     | 10d. Inside City Limits                            |
| Mary  | E 2   | ō                          | MD FRI  | EDERICK                                | FR                     | EDERI            | CK                  |                             |                                       |                |                     | 1 Yes 2 No   |
| Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. | 3a or 28e   | by Funeral Director        | 10e. Street and Number<br>595 CAWLEY I  | DRIVE                                  |                        | 10f. Zip         |                     |                             |                                       | 10g. Citizen   | of What Cou         | intry?   |
| deati   | E B   | Jerg                       | 11. Marital Status  | 12. Was Deceden                        | t Ever in U.S.         | 13. Was Dece     | dent of H           | ispanic Origin? (           | Specify Yes or No<br>rto Rican, etc.) | - 14.          | Race - Amer         |  |
| after e   | or 16   | Ē                          | 1 Never Married 2 Ma  | Armed Forces rried 1 Tes 25            | No                     |                  |                     |                             | rto Hican, etc.)                      |                | Black, White        |  |
| 215-0036 thin 72 hours aft  | <u> </u>  | db                         | 3 Widowed 4 □ Divorce   | d Year or Dates                        |                        | 1 🗆 Yes          | 21 No               | Specify:                    |                                       | Sp             | ecify: W]           | HITE   |
| 5-C   | natu<br>Heri  | Completed                  | 15. Decede<br>(Specify only high  | nt's Education<br>est grade completed) | 16a. D                 | ecedent's Usu    | al Occupa           | ation<br>during most of w   | orkina                                | 16b. Kind      | of Business/h       | ndustry  |
| 24 African  | L AND   | mpi                        | Elementary/Secondary (0-12)   |  | 5+)                    |                  |                     | during most of w            |                                       |                |                     |  |
| Ped will  | A di  |                            | 12  | ( )                                    | BE                     | AUTIC:           | IAN                 |                             |                                       |                | JTY SI              | HOP  |
| be fi   | ever  | Be                         | 17. Father's Name (First, Middle GEORGE WALTI   |  |                        |                  |                     |                             | ame (First, Middle<br>7 T M M D D     |                | mame)               |  |
| yle<br>bould  | narke   | To Be                      |   |  | ll a                   | _                |                     |                             | ZIMMER                                |                |                     |  |
| Maryland Id 2 should be filt  | n si /  |                            | 19a. Informant's Name/Relation J. ROLAND CH   |  |                        |                  |                     |                             | Rural Route Numb                      |                |                     |  |
| e, range 1 and 1 and 1 and 1 and 1  | ther i  |                            | 20a. Method of Disposition  | 11102/20M                              | 20b. Place of D        |                  |                     | N ROAD                      | , DAMAS                               |                |                     | 20872  |
| O Ses   | - io  |                            | 1 Burial 2 Cremation  |  | cemetery,              | crematory or o   | other plac          |                             |                                       |                | ion - City or T     |  |
| Baltimore,  | Jury  |                            | `4 □Donation 5 □Other (   |  | ST. MA                 |                  |                     | т. 12                       | /12/05                                | BARN           | VESVII              | LLE, MD  |
| Bal<br>permi  | any Ir  |                            | 21. Signature of Funeral Service  | Licensee                               |                        | 22. Name ar      |                     | ss of Facility UNERAL       | HOME                                  |                |                     |  |
|   |   |                            | 23a. Part1. Enter the disease, of   | er complications that cause            | od the death. De se    | P.Ö.             | BOX                 | 86, B                       | ARNESVI                               | LLE,           | MD 2                | 20838  |
| Pnys<br>/Me   | ician<br>dical  |                            | shock, or heart failure. Lis<br>fmmediate Cause (Final<br>disease or condition<br>resulting in death)       | a. Metal                               | iine.                  | lense            |                     | •                           | n of si                               | nallb          | owell               | Approximate<br>Interval Between<br>Onset and Death |
| Exar  | niner   |                            |   | Due to fix a                           | s a considerice of     |                  |                     |                             |                                       |                |                     |  |
|   |   | ē                          | Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury | b. Due to (or a                        | s a consequence of     | :                |                     |                             |                                       |                |                     |  |
| pen n   | ansit   | Examiner                   | Cause (Disease or injury  | <b>1</b>                               |                        |                  |                     |                             |                                       |                |                     |  |
| Э,  | ial-tr  | Exa                        | that initiated events<br>resulting in death) Last   | Due to (or a                           | s a consequence of)    | :                |                     |                             |                                       |                |                     |  |
| 760,<br>Ite be executed   | hysician and<br>the burial-transit                      | cai                        |   | d                                      |                        |                  |                     |                             |                                       |                |                     |  |
| 68<br>tiflicat  | g ph)<br>as th  |                            |   |  |                        |                  |                     |                             |                                       |                |                     |  |
| ecords, P.O. Box 68 law requires that the death certifical  | a attending physical for use as the t                   | Completed by Physician/Med | IF FEMALE:<br>23b. Was decedent pregnant<br>in the past 12 months?  |  | 2 Fetaf death          | 3 □Ectopic p     |                     |                             |                                       | 23d.           | Date of deliv       | rery<br>Day Year                                   |
| O. the de   | ned by the atter  | ysic                       | in the past 12 months?<br>1 □ Yes 2 No<br>9 □ Unknown   | 4□Pregnant<br>9□Unknown                | at time of death       | 5 ☐ Other (sp    | oecify)             |                             |                                       |                |                     | Duy Four   |
| d that  | ed by<br>detac  | P                          | Part II. Other significant condit   | ions contributing to death             | but not resulting in t | ne undertvinc o  | ause dive           | en in Part I.               | 23e. Did t                            | obacco use o   | contribute to t     | the cause of death?                                |
| Records,  | 500   | d b                        | Hunestonne  | notean                                 | Brosis                 | . 0              | 7 _                 | 1.1.0                       | 10                                    |                | -                   | bably 4 Dunknown                                   |
| O Joe   | nous  | ete                        | Parent  | 1 CS Carjo                             | 00000                  | p. Con.          |                     | uny                         | -                                     |                |                     |  |
| O -   | has<br>9e 2   | mpi                        | - Jeneamon  | ulls                                   | <del></del>            |                  |                     |                             | 24a. Was                              |                |                     | opsy findings available<br>empletion of cause of   |
|   | certificate<br>rector, pag                              |                            |   |  |                        |                  |                     |                             | 1 ☐ Yes                               | 2X No          | 1 Yes               | 2 No   |
| of Vital<br>Physician: T  | r this certifica<br>ral director, p                     | Be                         | 25. Was case referred to medic examiner?  | Hospital:                              |                        |                  | Othe                |                             | eath (Check only o                    |                |                     |  |
| Phy :   | raldi   | ٠ <u>.</u>                 | 1 Yes No  | I ☐ Inpat                              |                        |                  | JA                  | 4   Nursing                 | Home 5 Resident                       |                |                     | WHOSPICE   |
| C Ging  | Afte<br>fune  | tion                       | Natural 5 ☐ Pend  | 28a. Date of Ing<br>(Month, D          | ay Year) Inju          | iry M            | 28c. Injury<br>Work | <br Yes 2 □ No              | 200. Describe                         | iow injury oc  | Curred              |  |
| isio<br>Attendi<br>death.   | ctor:<br>y the  | fica                       | 3 ☐ Suicide 6 ☐ Could   | not be an Place of Is                  | njury - At home, farm  |                  |                     |                             | 28f Location /                        | Street and Ni  | umber or Rur        | al Route Number,                                   |
| Div<br>lor/   | d rin b   | Certification:             | 4 Homicide  | mined 289. Place of it                 | tc. (Specify)          | , 01.001, 100101 | y, onioo            |                             | City or Tox                           | vn, State)     | umbo, o, 11a,       | as Frodito Fulliper,                               |
| Hospitel  | rillex  |                            | 29a. Certifier Certify  | ng Physician: To the bes               | t of my knowledge, o   | feath occurred   | at the tim          | ne, date and place          | e, and due to the                     | cause(s) and   | manner as           | stated   |
| 9 Ho  | e Ful   | edical                     | (Check only 2 Medica one)   | Examiner: On the basis and manners     | of examination and/    | or investigation | , in my or          | oinion, death occ           | urred at the time,                    | date and pla   | ce, and due t       | o the cause(s)                                     |
| To the within 2   | To the Funeral Director:<br>completely filled in by the | Me                         | 29b. Signature and title of certific  | 9/10                                   | 111                    | 290              | c. License          | number                      |                                       | 29d. Date sig  | gned (Month,        | Day, Year)   |
|   |   |                            | 1/1/2   | ( If note                              | fil Imi                | ) 17             | 7 2                 | 2518                        | 2 7                                   | ben. 1         | 10 1                | ) Jone   |
|   |   |                            | 30. Name and address of perso   | who completed cause of                 | death (Item 23a) (To   | rpe, Print)      | /-                  | 1/0                         |                                       | cent           | ver/c               | 1000   |
| ,   |   |                            | Ali J.A   | Fronkte                                | 2/ 3/                  | 20 00            | 200                 | + goh                       | Stroot                                | Fra            | Spirit              | -4 MD  |
|   | Sta   | te                         | 31. Date filed (Month, Day, Yea   | 32. Re                                 | trar's Signature       | house            | 40                  |                             | 1                                     |                | 11/6                | 1  |
| F   | Registr   | ar                         | DEC   | 1 2 2005                               | MINE ST                | March            |                     |                             |                                       |                |                     |  |

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|  |  |                  | 637   | Please                     | State of Ma  |                                  |                      |                           |                           |                         |                           | -                              |                        | _                          | [ ] [                                 | 0.1                  |
|--|--|------------------|---|----------------------------|--|----------------------------------|----------------------|---------------------------|---------------------------|-------------------------|---------------------------|--------------------------------|------------------------|----------------------------|---------------------------------------|----------------------|
|  |  | 1                | For<br>State<br>Registrar   |                            |  | ,                                |                      | Certifica                 |                           |                         |                           |                                | Reg. No                | 000                        | 4101                                  | 3 1                  |
| nh.  |  | 74               | 1. Decedent's Name  | e (First, Middle, l        | Last)  |                                  |                      |                           |                           |                         |                           | 2. Date of Do                  | aath<br>Da             | y Year                     | 3. Time of                            | Death                |
| //   | ysicia<br>Iedic  | al .             |   | en Cook                    |  |                                  |                      |                           |                           |                         |                           | 12                             | 7                      | 200.                       |                                       | PPM                  |
| Ex   | amin   | er               | 4a. Facility Name (II   | _                          | rive street and number)                            | . 7                              | . 1                  |                           | 1                         | 1                       | of Death                  |                                | 40                     | County of De               |                                       |                      |
| Fun  | oral   |                  | 5. Social Security N  |                            |  |                                  | A. last birth        | day) If Unc               | ROSO<br>der 1 Year        | If Unde                 | er 24 Hrs.                | 8. Date of Bi                  | rth                    | <i>SAII</i> 9. Bi          | MORE thplace (State of                |                      |
| Dire   |  |                  | 212 36 4  |                            | 1 CM 2 □ F   | 69                               | Yr                   | s. Month                  | s Days                    | Hours                   | Min.                      | 8/5/19                         | 36 (Year)              |                            | yland                                 |                      |
| pue *  |  | -                | Usual Residence of<br>10a. State                                    | Decedent<br>10b. County    |  | 10c. Ci                          | tv. Town o           | or Location               |                           |                         |                           |                                |                        |                            | 10d. Inside C                         | ity I imits          |
| Manyli<br>f sho  | B D B  | ក្ត              | MD  | Baltim                     | ore  |                                  | Arbu                 |                           |                           |                         |                           |                                |                        |                            |                                       | 2 <b>X</b> No        |
| h the  | right  | irec             | 10e. Street and Nur   |                            |  |                                  |                      |                           | Zip Code                  |                         |                           |                                | 10g. Ci                | tizen of What C            | ountry?                               |                      |
| III. Z I Z I Z I Z I Z I Z I Z I Z I Z I   | d lan  | Funeral Director | 5552 Ash  | bourne 1                   | Road   |                                  |                      |                           | 2122                      | 27                      |                           |                                |                        | USA                        |                                       |                      |
| er dez<br>Items  | 9  | nue              | 11. Marital Status  |                            | 12. Was Decedent<br>Armed Forces?                  |                                  | .S.                  | 13. Was Dec<br>If Yes, sp | cedent of F<br>pecify Cub | tispanic C<br>an, Mexic | rigin? (Spe<br>an, Puerto | ecify Yes or N<br>Rican, etc.) | 0-                     | 14. Race - Am<br>Black, Wh |                                       |                      |
| urs aft  | E SECTION AND ADDRESS OF THE PERSON AND ADDR | by               | 3 Widowed   | ed 2 Married<br>4 Divorced | 1 ☐ Yes & ☐ If Yes, Give Year or Dates:            | NO                               |                      | 1 🗆 Yes                   | 2 <b>X</b> No             | Specif                  | y:                        |                                |                        | Specify: Wh                | ite                                   |                      |
| 72 ho  | ical.  | Completed        | (Spec   | 15. Decedent's             | Education<br>grade completed)                      |                                  | 16a. D               | ecedent's Us              | sual Occup                | oation                  | ost of work               | ına                            | 16bK                   |                            | ebral P                               | 2107                 |
| Mithin her   | e Max  | mpig             | Elementary/Secon  |                            | College (1-4or 5                                   | 5+)                              |                      | Give kind of vite. DO NOT |                           | d)                      |                           | 9                              |                        |                            | Maryla                                |                      |
| filed v<br>Hygie   | aut.   |                  | 17. Father's Name (   | (First, Middle, La         | •  |                                  | THE                  | ructo                     | <u>L</u>                  | 18. Moti                | her's Name                | e (First, Middle               | <u> </u>               |                            |                                       |                      |
| lid be<br>lental   | ic s   | To Be            | John Or   | en Cook                    |  |                                  |                      |                           |                           |                         |                           |                                |                        |                            |                                       |                      |
| 2 should be filed within and Mental Hygiene.   | auma   |                  | 19a. Informant's Na   |                            | (Type, Print)                                      | _                                | 19b. N               | Mailing Addre             | ss (Street                | and Numi                | ber or Rura               | irgini<br>al Route Numb        | er, City               | or Town, State,            | Zip Code)                             |                      |
| politimical ey, intally interpreted to the political political permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mantal Hygiene. Important: if itsm 27 is marked other than "natural", or items 23a or 28s-1 show  | her tr   |                  | Cheryl Je   |                            | Sister/  |                                  |                      | 2 Ashb                    |                           |                         |                           | rbutus                         |                        |                            | · · · · · · · · · · · · · · · · · · · |                      |
| Pages 1  | or of  |                  |   | Cremation 3                | ☐Removal from State                                | 20b. F                           | Place of Disemetery, | rematory of Park          | lame of<br>r other pla    | ce)                     |                           | 2 / 2005                       |                        | ocation - City o           |                                       |                      |
| artmer   | injury   | -                | 4 ☐ Donation<br>21. Signature of Fu                                 | 5 Other (Spec              |  | 100                              | udom                 |                           |                           |                         |                           |                                |                        | timore,                    | mily FH                               | Tnc                  |
| permit.<br>Departr<br>Importe  | any ii   |                  | 1/on  | v/R                        | adde Mil   | 1442                             | 2                    | 4112                      |                           |                         |                           |                                |                        | tt City                    |                                       | 1043                 |
| ·  | No.  |                  | 23a. Part1. Enter the   | ne disease, or co          | mplications that caused<br>by one cause on each li | d the deat                       | h. Do no             | enter the m               | ode of dyir               | ng, such a              | s cardiac o               | or respiratory a               | rrest,                 |                            | Approximat<br>Interval Bet            | 0<br>WARD            |
| Physic   | ian  |                  | Immediate Cause (   | Final                      | AGUT   | P.                               | MI                   | I,                        |                           |                         |                           |                                |                        |                            | Onset and                             |                      |
| /Med<br>Exami  |  |                  | resulting in death)   | -                          | Due to (or as                                      | a conseq                         | uence of)            | :                         |                           |                         |                           |                                |                        |                            |                                       |                      |
|  |  | -                | Sequentially list cor<br>if any, leading to im<br>cause. Enter Unde | nditions,                  | b. DiADE  Due to (or as                            | a consec                         | Suence of)           | •                         |                           |                         |                           |                                |                        |                            |                                       |                      |
| uted   | ansit  | Examiner         | cause. Enter Unde<br>Cause (Disease or<br>that initiated events     | injury                     |  |                                  | ,                    |                           |                           |                         |                           |                                |                        |                            |                                       |                      |
| te be executed ysicien and   | ırıal-tr   |                  | resulting in death) L   | .ast                       | Due to (or as                                      | a conseq                         | uence of)            |                           |                           |                         |                           |                                |                        |                            |                                       |                      |
| ate be   | the bu   | lical            |   |                            | d  |                                  |                      |                           |                           |                         |                           |                                |                        |                            |                                       |                      |
| Sentific ding p  | Seas   | Physician/Medi   | IF FEMALE:  |                            | 23c. If yes, outcome                               | of preops                        | ancv                 |                           |                           |                         |                           | _                              |                        |                            |                                       |                      |
| etten etten  | tor u  | cian             | in the past 12  | months?                    | 1 ☐ Live birth<br>4 ☐ Pregnant at                  | 2 Feta                           | il death             | 3□Ectopic<br>5□ Other (   |                           | y                       |                           |                                |                        | 23d. Date of de<br>Month   | ,                                     | Year                 |
| t the c  | achec  | hysi             | 9 Unknown   | 1140                       | 9□ Unknown   |                                  |                      |                           |                           |                         |                           |                                |                        |                            |                                       |                      |
| es tha   | ep eq  | by P             | Part II. Other signif   | icant conditions           | contributing to death b                            | ut not res                       | ulting in th         | ne underlying             | cause giv                 | en in Part              | t I.                      | 23e. Did                       | tobacco                | use contribute             | o the cause of c                      | eath?                |
| requir   | pinor  | ted              |   |                            |  |                                  |                      |                           |                           |                         |                           | 10                             | Yes 2                  | <b>2</b> № 3□P             | robably 4 🗆 l                         | Jnknown              |
| e law  | 99 2 sl  | Completed        |   |                            |  |                                  | -                    |                           |                           |                         |                           | 24a. Was                       |                        | prior to                   | utopsy findings<br>completion of c    | available<br>ause of |
| n: Th<br>ficete  | or, pag  | CO               | 25. Was case refer  | rad to madical             |  |                                  |                      |                           |                           |                         |                           | 1 ☐ Yes                        | 2 No                   | death?                     | s 2□ No                               |                      |
| ysicia   | direct   | To Be            | examiner?   |                            | Hospital:  | ent 210                          | EB/Outo              | atient 3 🗆 [              | Oth Oth                   | 000                     |                           | Check only                     |                        | 6 □Other (Spi              | no.fu)                                |                      |
| fe fa  | nerai  |                  | 27. Manner of Death   | h<br>5 ☐ Pending           | 28a. Date of Inju<br>(Month, Da                    | ry                               | 28b. Tim             | ne of                     | 28c. Injur<br>Wor         |                         |                           | 28d. Describe                  |                        |                            | iony)                                 |                      |
| tendii<br>leath.   | the fu   | catic            | 2 Accident  | investigati                | ion  | , .                              |                      | М                         | 10                        | Yes 2                   |                           |                                |                        |                            |                                       |                      |
| or At<br>after d   | in by  | Certification:   | 4 Homicide  | determine                  |  | ury - At he<br>c. <i>(Specif</i> | ome, farm<br>(y)     | , street, facto           | ory, office               |                         | :                         | 28f. Location (<br>City or To  | Street an<br>wn, State | nd Number or F<br>e)       | ural Route Num                        | ber,                 |
| To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the ettending phys  | De III   |                  | 29a. Certifier  | Certifying                 | Physician: To the best                             | of my kno                        | wledge.              | death occurre             | ed at the fir             | ne, date a              | and place                 | and due to the                 | Calisole               | and manner a               | s stated                              |                      |
| n 24 h   | oletely  | edicai           | (Check only one)  | 2 ☐ Medical Ex             | aminer: On the basis of<br>and manner sta          | t examina                        | ition and/           | or investigation          | on, in my o               | pinion, de              | ath occurr                | ed at the time,                | date and               | d place, and du            | e to the cause(s                      | )                    |
| To the To | Eloo   | ž                | 29b. Signature and  | title of dertifler         |  |                                  |                      | 2                         | 9c. Licens                | e number                | 7                         |                                | 29d. Da                | te signed (Mon             | th, Day, Year)                        |                      |
|  |  |                  | 1 (   | 1/1                        | 340  |                                  |                      |                           | 10                        | 51                      | 2/4                       |                                | 12                     | 17                         | 1200                                  | T                    |
| ) (e)  |  |                  | -4 4  | 1. //                      | o completed cause of d                             | leath (Iten                      | n 23a) (Ty           | rpe, Print)               | - ۸. ر                    | - 10-                   | ايم                       | T                              |                        | 110 1                      | ( 4 2 7                               |                      |
|  | Stat   | e                | DR ERIC<br>31. Date filed (Mont                                     | th, Day, Year)             |  | ar's Signa                       | iture                | oqu                       | ARE                       | - UR                    | DAI                       | IIMOK                          | £,                     | Md 2                       | 1251                                  |                      |
| Re   | gistra   |                  |   | DEC 1                      | 2 2005   | Pege -                           | H                    | 1                         | 100                       |                         |                           |                                |                        |                            |                                       |                      |

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OREN COOK

State of Maryland / Department of Health and Mental Hygiene state Amend #8, #18, 12-21-05, per Final Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Year **Physician** 700AM Jerome M. Carlin December 10 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 4934 Montgomery Road Ellicott City Howard If Under 1 Year | If Under 24 Hrs. 6. Sex 1**%** M 2□ F 5. Social Security Number 7. Age (In yrs. last birthday) B. Date of Birth March
 One of Birth March
 State or Foreign Country
 One of Birth March
 One of **Funeral** Days Hours Yrs. Apr 23, 1941 Maryland Director 220 36 2926 64 Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City. Town or Location 10d, Inside City Limits r then "naturel", or iteme 23s or 28s-f ehow the Medical Exeminer must be notified at 1 Yes 2X No Director MD Howard Ellicott City 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 4934 Montgomery Road 21043 United States death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 11. Marital Status e filed within 72 hours after al Hygiene. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 TNo Specify: Specify δ 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) 8 Mulch Manufacturer Self Employed es 1 and 2 should be filed of the light of Health and Mental Hygie filem 27 is marked other in other traumatic event, it 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William J. Carlin Anna Leppert Anne Leppert ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ruth E. Carlin/Wife 4934 Montgomery Road Ellicott City, MD 21043 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ②Cremation 3 ☐ Removal from State Department of Important: If any injury or once. 12-15-2005 Catonsville, MD 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory 22. Name and Address of Facility Harry H. Witzke's Family FH Inc. 21. Signature of Funeral Service bicensee M01044 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner teriosclorotie CARDIDVASCULA DISPET YEWS. Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner physician and the burial-transit death certificate be executed resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical use as the attending p for use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 4☐Pregnant at time of death 5 Other (specify) ed by the a 1 ☐ Yes 2 ☐ No 9 Unknown signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown certificate has been si rector, page 2 should Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death? 2 1 No 1 ☐ Yes 2 ☑ No 1 Yes Hospital or Attending Physician: After this certific funeral director, Be 25. Was case referred to medical 26. Place of Death | Check only one) examiner? Other: 1 ☐ Yes 2 ☑ No 1 Inpatient 2 □ ER/Outpatient 3 □ DOA 4 Nursing Home 5 √ Residence 6 Other (Specify) 27. Mann of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 28b. Time of 28d. Describe how injury occurred 1 V Natural Injury s after des. 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicai 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the within 2 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) who completed cause of death (Item 23a) (Type, Print) 30. Name and address of AIR DHV ENLICOT C-18 2807 State Registrar

|             |  |                | For<br>State<br>Registrar   | State of Ma  | ryland / Depa<br><i>Cei</i>   | artment of F                                     |   |  | ieße) () 5<br>og. No.                               | 41583                                 |
|-------------|--|----------------|---|--|---|--|---|--|---|---------------------------------------|
|             |  | <              | Decedent's Name (First, Middle,   | Last)  |   |  |   | 2. Date of Death                             | h<br>Day Yeer                                       | 3. Time of Death                      |
|             | Physici<br>/Medic  |                | Rosie   | Elizabeth  | Divelbiss   |  |   | Decembe                                      |   | 12:35 A <sup>M</sup>                  |
|             | Examin   |                | 4a. Facility Name (If not institution,  | give street and number)  |   | 4b. City, Town, o                                | r Location of Death                         |  | 4c. County of Death                                 |                                       |
|             |  |                | Memorial Hosp   | ital   |   | Cumbe  |   |  | Allegany  |                                       |
|             | Funeral<br>Director  |                | 5. Social Security Number 235-32-6806   | 6. Sex 7. Age  | (In yrs. last birthday) Yrs.  | Months Days                                      | If Under 24 Hrs.<br>Hours Min.              | 8. Date of Birth<br>(Month, Day,<br>Jan 29,  | 1920 9. Birth                                       | place (State or Foreign               |
|             | P.   |                | Usual Residence of Decedent   |  |   |  |   |  |   | 40d Incide Ciby Limite                |
|             | anyla<br>shov  | ᆫ              | MD 10b. County Allega   | anv  | 10c. City, Town or Lo   | erland   |   |  |   | 10d. Inside City Limits  V☐ Yes 2☐ No |
|             | the M  | Director       | 10e. Street and Number  | 2119   |   | 10f. Zip Code                                    |   | 1/   | Og. Citizen of What Cou                             |                                       |
|             | with a or  |                | _   | oot  |   |  | 21502                                       |  | USA   | ,                                     |
|             | ns 23  | era            | 106 1/2 Arch Stre   | 12. Was Decedent E   | ever in U.S. 13.  | Was Decedent of H                                | lispanic Origin? (Sp                        | ecify Yes or No-                             | 14. Race - Ameri                                    | can Indian,                           |
| 36          | permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23e or 28e-f show may injury or other traumatic event, the Medical Expresser must be incuffed at once.   | by Funeral     | 1 ☐ Never Married 2 ☐ Marrie  | Armed Forces?  and 1 Tyes 2 No  If Yes, Give  Year or Dates:               |   | If Yes, specify Cuba<br>1 ☐ Yes                  | an, Mexican, Puerto<br>Specify:             | Rican, etc.)                                 | Specify: White                                      |                                       |
| 215-0036    | 2 hou  | Completed      | 15. Decedent  |  | 16a. Dece   | dent's Usual Occup                               | pation                                      | ina  | 16b. Kind of Business/Ir                            |                                       |
| 2           | thin 7   | ple            | (Specify only highest<br>Elementary/Secondary (0-12)  | College (1-4or 5-  | +) (Give  | DO NOT use retired                               | during most of work<br>d)                   |  |   |                                       |
| 7           | filed wil<br>Hygien<br>other the   | 9              | 12  |  | Homen   | naker  |   |  | wn Home   |                                       |
| 2           | be filed<br>ntal Hygi<br>ad other<br>event, I  | Be             | 17. Father's Name (First, Middle, L   |  |   |  | 18. Mother's Nam                            |  |   | hlitar                                |
| <u>ya</u>   | should be<br>nd Mental<br>marked c   | ၉              | Walter T. Lech  |  |   |  |   | · · · · · · · · · · · · · · · · · · ·        | Simkus) Lec   |                                       |
| Maryland    | d 2 shouth and the modern traum  |                | 19a. Informant's Name/Relationsh<br>Paulette Durbin   | <sub>iip (Type, Print)</sub><br>daugh                                      |   | ng Address (Street<br>Box 90                     | and Number or Run                           | a <i>l R</i> oute Number,<br><b>Fort A</b> s | City or Town, State, Zij                            | / <b>26</b> 719                       |
| re,         | thealth<br>tem 27<br>other tr  |                | 20a. Method of Disposition  |  | 20b. Place of Dispo   | osition (Name of                                 | 201   | Date 2                                       | 20c. Location - City or T                           | own, State                            |
| OL          | Pages<br>nent of<br>int: If it   |                | 1 🔀 Burial 2 □ Cremation  4 □ Donation 5 □ Other (Sp  |  |   | nnette Cem                                       | etery                                       | 12/21/2005                                   | Short Gap   | WV                                    |
| Baltimore,  | permit. Page<br>Department<br>Important: If<br>any Injury or<br>once.  |                | 21. Signature of Funeral Service L  |  | 1/1 2   |  | ss of Facility<br>i Funeral Ho              | me, PA                                       |   |                                       |
|             |  |                | 23a. Part1. Enter the disease, or shock, or heart failure. List of  | complication that caused   | the death. Do not ent   | 108 Virg   | inia Avenue                                 | Cumberla                                     | ind, MD 21502                                       | Approximate                           |
| 8760, <     | /Medical Examiner transit the prival-transit   | dical Examiner | Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | Due to (or as a Due to (14 as a Africa                                     | a consequence of):  Stue a consequence of):  Libril a consequence of):  Small | lation   | Sulmona<br>failum                           | ny Dis                                       | an  | Onset and Death                       |
| P.O. Box 68 | The law requires that the death certifics to the steeding phate has been signed by the attending phates as the second of the sec | Physician/Med  | JF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 M No 9 ☐ Unknown   | 23c. If yes, outcome of 1 Live birth 2 4 Pregnant at 19 Unknown            | 2 ☐ Fetal death 3 ☐   | □Ectopic pregnancy                               | <i>y</i>                                    |  | 23d. Date of deliv                                  | eery<br>Day Year                      |
| Ś           | uires that i<br>signed by<br>Id be deta  | by             | Part II. Other significant conditio   | ns contributing to death bu  | It not resulting in the u   | Inderlying cause giv                             | ven in Part I.                              | 23e. Did tob                                 | vacco use contribute to                             | the cause of death?                   |
| Record      | w requir<br>been si<br>should  | Completed      | 7   |  |   | •  |   | 24a. Was ar                                  | 24b. Were auto                                      | opsy findings available               |
| Re          | The law<br>sate has<br>page 2.   | Ĕ              |   |  |   |  |   | autopsy                                      | y prior to coned? death?                            | ompletion of cause of                 |
| Vital       |  | ပိ             | 25. Was case referred to medical  |  |   |  | 26 Place of Deat                            | 1 ☐ Yes 2<br>h (Check only one               |   | 2□ <b>4</b> 0                         |
|             | Physician:<br>r this certific<br>ral director,   | To B           | examiner?   | Hospital:  | nt 2 ☐ ER/Outpatie  | nt 3□ DOA Oth                                    |   |  | nce 6 □Other (Speci                                 | (h)                                   |
| n of        | ing Phy<br>After thi<br>uneral c   |                | 27. Manner of Death  ☐ Natural 5 ☐ Pending  | 28a. Date of Injury<br>(Month, Day   | y 28b. Time o   | of 28c. Injur<br>Wor                             | y at<br>rk?                                 | 28d. Describe ho                             |   | 77                                    |
| Division of | To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.  | Certification; | 2 Accident investig 3 Suicide 6 Could n 4 Homicide determi  | not be go Pleas of Injur   | iry - At home, farm, st<br>:. (Specify)                                       |  | Yes 2 No                                    | 28f. Location (Str.<br>City or Town          | reet and Number or Rur<br>n, State)                 | al Route Number,                      |
| Revolt.     | To the Hospital or within 24 hours after To the Funeral Dir completely filled in it  | edical Co      | 29a. Certifier 116 Certifyin<br>(Check only 2 Medical i   | g Physician: To the best of<br>Examiner: On the basis of<br>and manner sta | examination and/or in   | th occurred at the tile<br>evestigation, in my o | me, date and place,<br>opinion, death occur | and due to the ca<br>red at the time, da     | ause(s) and manner as a<br>ate and place, and due t | stated.<br>to the cause(s)            |
|             | vithin<br>o the<br>omple   | Me             | 29b. Signature and title of certifier   |  |   | 29c. Licens                                      | se number                                   | 29   | 9d. Date signed (Month,                             | Day, Year)                            |
|             | ₩ > W ()   |                | 1 Alms  | _  |   | D62  | 429   |  | December 1  | 9, 2005                               |
|             |  |                |   | who completed cause of de  |   |  |   |  |   |                                       |
|             | 5  |                | Dr. A. Saleem,  | 500 Memorial   | Avenue, S   | Suite 105  | , Cumber1                                   | and, MD                                      | 21502   |                                       |
|             | Sta<br>Regist  |                | 31. Date filed (Month, Day, Year)   | 3 2005 32. Segistra  | ar's Signature  | poels  |   |  |   |                                       |

|                                |  |                | For State   | State of                                   | Maryland  |                        | rtment of Health   |                                | ntal Hygiei<br>Reg.                    | _ 4 U U a                        | 41584                           |
|--------------------------------|--|----------------|---|--|---|------------------------|--|--------------------------------|--|----------------------------------|---------------------------------|
|                                |  |                | Registrar  1. Decedent's Name (First, Middle                                  | , Last)                                    |   |                        |  |                                | . Date of Death                        |                                  | 3. Time of Death                |
| ш                              | Physicia   | _              | Evelyn F. Deega   | n  |   |                        |  | De                             | Month<br>ecember                       | Day Year 2005                    | 1:45 P <sup>M</sup>             |
|                                | /Medic<br>Examin   |                | 4a. Facility Name (If not institution   |  | n <i>ber)</i>                                   |                        | 4b. City, Town, or Location  |                                |  | 4c. County of Death              |                                 |
|                                |  |                | Hillhaven Nursi   | ng Home                                    |   |                        | Adelphi  |                                |  | Prince Ge                        |                                 |
|                                | Funeral  |                |   | 6. Sex<br>1 □ M 2 🛣 F                      | 7. Age (In yrs. I                               |                        | If Under 1 Year If Under Months Days Hours   | Min.                           | . Date of Birth<br>(Month, Day, Ye     | ar) Cou                          | place (State or Foreign intry)  |
|                                | Director   |                | 577-01-4537 Usual Residence of Decedent                                       | 10 101 2020                                | 93  | Yrs.                   |  |                                | Jan. 18,                               | 1912 Was                         | hington, DC                     |
|                                | and and  | 1              | 10a. State 10b. County  |  | 10c. City                                       | , Town or Lo           | ation  |                                |  |                                  | 10d. Inside City Limits         |
|                                | Mary   | to             | MD Prince   | George's                                   | В   | eltsvi                 | 11e  |                                |  |                                  | 1 ☐ Yes 2 🛣 No                  |
|                                | r 286  | Director       | 10e. Street and Number  |  |   |                        | 10f. Zip Code  |                                | 10g.                                   | Citizen of What Cou              | intry?                          |
|                                | th wit   | alD            | 4316 Knott Stre   | et   |   |                        | 20705  |                                |  | United St                        | ates                            |
|                                | r dea  | Funeral        | 11. Marital Status  | 12. Was Dece<br>Armed Fo                   |   | S. 13. V               | Vas Decedent of Hispanic O<br>Yes, specify Cuban, Mexica   | rigin? (Speci<br>an, Puerto Ri | fy Yes or No-<br>can, etc.)            | 14. Race - Ameri<br>Black, White |                                 |
| 36                             | within 72 hours after death with the Maryland<br>ene.<br>Then "naturel", or items 23a or 28e-f ehow<br>na Mcdical Exercities mant the notified at  | by Fu          | 1 ☐ Never Married 2 ☐ Marri<br>3 ☑ Widowed 4 ☐ Divorced                       | ed 1 Tes<br>If Yes, Giv<br>Year or Da      | е   | 1                      | ☐ Yes 2M No Specify  | y:                             |  | Specify: Wh                      | ite                             |
| Ş                              | hour<br>fure   | ed b           | 15. Decedent  |  | a 105.  | 16a. Deced             | ent's Usual Occupation   |                                | 166                                    | . Kind of Business/Ir            | ndustry                         |
| 7.                             | in 72  | Completed      | (Specify only highes<br>Elementary/Secondary (0-12)                           | t grade completed) College (1              | -405 5+1  | (Give<br>life. (       | kind of work done during mo<br>OO NOT use retired)   | st of working                  | A:                                     | merican                          | ,                               |
| 212                            | d with   | E              | Elementary/Secondary (0-12)   | 2  | -401 57)  | Super                  | visor Analys:  | is Dep                         | art.                                   | Security                         | & Trust                         |
| פ                              | al Hyg   | Be C           | 17. Father's Name (First, Middle,   | Last)                                      |   |                        |  |                                | First, Middle, Maid                    | den Surname)                     |                                 |
| yla                            | 2 should be filed within 72 hours after death with the Marylan and Membal Hygiene a and Membal Hygiene is marked other then "naturet, or items 23a or 28e-f show reumatic event, in a Modical Exercities marked and reumatic | 2              | Claude Fenton   |  |   |                        |  | y Jehl                         |  |                                  |                                 |
| ä                              | 2 sh<br>and<br>is m  |                | 19a. Informant's Name/Relations   |  |   |                        | g Address (Street and Num  |                                |  |                                  | p Code)                         |
| e,                             | 1 and 3<br>Health<br>tem 27<br>other tra   |                | Charles C. Deeg   | an, son                                    | 20b. P  | lace of Dispo          | Knott Street   | , Belt:                        |  | Location - City or T             | own, State                      |
| no<br>P                        | Pages<br>nent of<br>int: If it   |                | 1 Burial 2 ☐ Cremation  4 ☐ Donation 5 ☐ Other (S)                            |  | State   |                        | natory or other place)   | 12 00                          | 2005 C.                                | deland M                         | D                               |
| Baltimore, Maryland 21215-0036 | 그른흔들기  |                | 21. Signature of Funeral Service  | and the same                               | Ced   |                        | 1 Cemetery   Name and Address of Fac   |                                |  | itland, M<br>i Euperal           |                                 |
| Ba                             | Depa<br>Impo<br>any ir   |                | Tame !  | N le                                       | Won   |                        | 800 New Hamps  |                                |  |                                  |                                 |
| N                              |  |                | 23a Part1. Enter the disease, or sheck, or heart failure. List                | complications that controls one cause on e | aused the death                                 | n. Do not ent          | er the mode of dying, such a   | as cardiac or                  | respiratory arrest,                    |                                  | Approximate<br>Interval Between |
| 1 to 1                         | Physician  |                | Immediate Cause (Final disease or condition                                   |  | eumonia   |                        |  |                                |  | 15                               | Onset and Death Days            |
| A STATE OF                     | /Medical   |                | resulting in death)   | Due to                                     | (or as a consequ                                | uence of):             |  |                                |  |                                  |                                 |
| Ш                              | Examiner   | _              | Sequentially list conditions, if any, leading to immediate                    | b  | (or as a consequ                                |                        |  |                                |  |                                  |                                 |
|                                | ed isit  | line           | if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | Due to t                                   | (or as a consequ                                | uence on:              |  |                                |  |                                  |                                 |
|                                | xecut<br>and<br>al-trar  | Examiner       | that initiated events resulting in death) Last                                | c.<br>Due to                               | (or as a consequ                                | uence of):             |  |                                |  |                                  |                                 |
| 8760,                          | death certificate be executed e attending physician and id for use as the burial-transit   | dicai E        |   | d  |   |                        |  |                                |  |                                  |                                 |
| 68                             | tificate<br>ig phys<br>as the  | ledi           |   |  |   |                        |  |                                |  |                                  |                                 |
| Вох                            | leath certifica<br>attending ph<br>I for use as t  | Physician/Me   | IF FEMALE:<br>23b. Was decedent pregnant                                      |  | tcome of pregna                                 |                        | Ectopic pregnancy  |                                |  | 23d. Date of deliver Month       | very<br>Day Year                |
| П                              | at the dea<br>by the att   | sici           | in the past 12 months? 1 ☐ Yes 2X2No 9 ☐ Unknown                              | 4☐Pregn<br>9☐Unkn                          | nant at time of di<br>own                       | eath 5□                | Other (specify)  |                                |  | I WOUTH                          | ouy rou.                        |
| P.0                            | The law requires that the site has been signed by the bage 2 should be detached.   | Phy            | Part II. Other significant condition  | ons contributing to d                      | eath but not resi                               | ulting in the u        | nderlying cause given in Par   | t I.                           | 23e. Did tobac                         | co use contribute to             | the cause of death?             |
| ds,                            | signed<br>be de  | d by           | , and a second  |  |   |                        | ,,,  |                                | 1 ☐ Yes                                | 2 <b>∑</b> No 3 □ Pro            | bably 4 Unknown                 |
| of Vital Records,              | w requir<br>been si<br>should  | Completed      |   |  |   |                        |  |                                | 24a. Was an                            | 24b. Were aut                    | opsy findings available         |
| Rec                            | The lay  | фшо            |   |  |   |                        |  |                                | autopsy<br>performer                   | prior to c                       | ompletion of cause of           |
| Ta I                           |  |                | 25. Was case referred to medica   |  |   |                        | 26. Pla  | ce of Death /                  | 1 Yes 2 Check only one)                | NO I THES                        | 2 No                            |
| <u> </u>                       | X S D  | o Be           | examiner?<br>1 ☐ Yes 2 🛣No  | Hospitali                                  | Inpatient 2 🗆                                   | ER/Outpatier           |  |                                |  | e 6 Other (Spec                  | ify)                            |
|                                | ding Ph<br>h.<br>After th<br>funeral   | n: T           | 27. Manner of Death 1 XNatural 5 ☐ Pendir                                     | 28a. Date<br>(Mon                          | of Injury<br>th, Day Year)                      | 28b. Time of<br>Injury | The same of the sa | -                              | d. Describe how                        |                                  |                                 |
| sioi                           | Attending r death. sctor: After by the fune  | catic          | 2 Accident investi  | gation                                     |   |                        | M 1 ☐ Yes 2 [  |                                |  |                                  |                                 |
| Division                       | for Attendater deatl   | Certification: | 3 Suicide 6 Could 4 Homicide determ   | inad 200. Place                            | e of Injury - At ho<br>ing, etc. <i>(Specif</i> | ome, farm, str<br>y)   | eet, factory, office   | 28                             | If. Location (Stree<br>City or Town, S | et and Number or Ru<br>State)    | ral Route Number,               |
|                                | Hospital 24 hours a Funerel D tely filled i  |                | 29a. Certifier 1 Certifyir  | og Physician: To the                       | a hest of my kno                                | wledge deat            | occurred at the time, date   | and place, an                  | nd due to the caus                     | e/s) and manner as               | stated                          |
|                                | To the Hospital or Attending within 24 hours after death.  To the Funerel Director: After completely filled in by the funer  | edical         |   | Examiner: On the b                         |   |                        | vestigation, in my opinion, d  |                                |  |                                  |                                 |
|                                | To the within 2 To the comple  | Me             | 29b. Signature and title of certific  | 11/1                                       |   |                        | 29c. License numbe   |                                | 29d.                                   | Date signed (Month               | , Day, Year)                    |
|                                | 6  |                | 1/1/1   | Ulles                                      | The   |                        | D240   | 93                             | De                                     | ecember 6,                       | 2005                            |
|                                | 1  |                | 30. Name and address of person  |  | se of death (Item                               | n 23a) (Type,          | Print)   | 200 1                          | ) for and a 1                          | MD 20-                           | 737                             |
|                                |  |                | Mark A. Parkhu  |  | D/II  | sarvis                 | Avenue Suite   | = 400 h                        | Tverdar6                               | e, MD 207                        | . 37                            |
|                                | St<br>Regist   | ate<br>rar     | 31. Date filed (Month, Day, Year)   | 2000                                       | Registrar's Signa                               | ature                  |  |                                |  |                                  |                                 |
|                                | 3  |                | 1150 0 3  | LOUIS ANTO                                 | Property of the Parket                          | - 1                    |  |                                |  |                                  |                                 |

|           |   |               | State of Maryland / [ | Department of Heal<br>Certificate of Dea   |                  | ental Hygie<br>Reg.                    | 6000                          | 41585  |
|-----------|---|---------------|---|--|------------------|--|-------------------------------|--|
| Æ         | - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1   |               | Decedent's Name (First, Middle, Last)   |  |                  | Date of Death     Month                | Day Year                      | 3. Time of Death                                 |
|           | Physicia<br>/Medic  | _             | Raymond Lee Disney  |  |                  | December                               | 6, 2005                       | 9:03 A M   |
|           | Examin  | er            | 4a. Facility Name (If not institution, give street and number)  Anne Arundel Medical Center   | 4b. City, Town, or Loca<br>Annapo  |                  |  | 4c. County of Deat            | h<br>Arundel                                     |
|           | Funeral   |               | 5. Social Security Number 6. Sex 7. Age (In yrs. last bir   | thday) If Under 1 Year If L  | Jnder 24 Hrs.    | 8. Date of Birth                       |                               | thplace (State or Foreign                        |
|           | Director  |               | 212-20-1430   | Yrs. Months Days Ho  | ours Min.        | (Month, Day, Ye Sept. 11               | , 1931 M                      | laryland   |
|           | and and   |               | Usual Residence of Decedent           10a. State         10b. County         10c. City, Town  | or Location  |                  |  |                               | 10d. Inside City Limits                          |
|           | Mary<br>I sho   | tor           | Maryland Anne Arundel   | Annapoli   | is               |  |                               | 1XQXYes 2 ☐ No                                   |
|           | filed within 72 hours after death with the Maryland<br>Hygione.<br>Inthe rhan "natural", or Itams 23a or 28a-f show<br>ent, tre Medical Evanther must be notified at                  | Director      | 10e. Street and Number  | 10f. Zip Code  | 24.404           | 10g.                                   | Citizen of What Co            | ountry?  |
|           | s 23s   | rail          | 212 N. Glen Avenue  11 Marital Status 12. Was Decedent Ever in U.S.   |  | 21401            | aibi Vaa as Na                         | U.S.A.                        | vican Indian                                     |
|           | fter de   | Funeral       | 11. Marital Status  1 ☐ Never Married 2 ☑ Married  1 ☐ Never Married 2 ☑ Married  | 13. Was Decedent of Hispan<br>If Yes, specify Cuban, Me                                    |                  | Rican, etc.)                           | Black, White                  | e, etc.  |
| 3         | rai', o   | by            | 3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates: 1954–55  | 1 ☐ Yes 2X No Sp   | pecify:          |  | Specify: Wh                   | ite  |
| ה<br>ה    | "natu   | Completed     | 15. Decedent's Education (Specify only highest grade completed)   | Decedent's Usual Occupation<br>(Give kind of work done during<br>life. DO NOT use retired) | g most of workin | 16                                     | b. Kind of Business/          | findustry  |
| 7         | withir<br>iene.<br>r then   | dmo           | Elementary/Secondary (0-12) College (1-4or 5+)  | Civil Service  |                  |  | CIA                           |  |
| 2         | e filed<br>at Hyg<br>other  | Be C          | 17. Father's Name (First, Middle, Last)   |  |                  | (First, Middle, Mai                    | den Sumame)                   |  |
| <u> </u>  | should be filed within and Mental Hygiene. s marked other then umatic event, It e Me  | To E          | William E. Disney   |  | Ethel Wa         |  |                               |  |
| Š         | d 2 d d 2 d d d d d d d d d d d d d d d   |               |   | . Mailing Address (Street and No. Glen Aver  |                  |  |                               | Zip Code)<br>21401                               |
| <u>วี</u> | ages 1 a<br>nt of Hea<br>:: if item<br>: or othe  |               | 1 ₺ Burial 2 □ Cremation 3 □ Removal from State   | Disposition (Name of y, crematory or other place) rgaret's Cem.                            | 12/10/           |  | c. Location - City or         | Town, State Maryland                             |
|           | permit. Pages 1 an<br>Department of Heal<br>Important: if Item 2<br>any injury or other<br>2005.  |               | 4 Donation 5 Other (Specify)  21. Signature of Faneral Serving Licensee   | 22. Name and Address of  | Facility Joh     | n M. Tay                               | lor Funer                     | al Home  |
| 270       | <u>205</u> a  |               | 23a. Part 1. Enter the disease, or complications that caused the death. Do  | 147 Duke of O  |                  |  |                               | Approximate Interval Between                     |
|           | Physician   |               | shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition  a  | ia   |                  |  |                               | Onset and Death                                  |
|           | /Medical<br>Examiner  |               | resulting in death)  Due to (or as a consequence  | of):   |                  |  |                               |  |
| 24        | nsit  | Examiner      | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury   | of);   |                  |  |                               |  |
| Ď,        | ficate be executed<br>physicien and<br>s the burial-transit   | i Exa         | that initiated events resulting in death) Last C Due to (or as a consequence  | of):   |                  |  |                               |  |
| 00/00     | physic<br>physic<br>s the b   | edlcai        | d   |  |                  |  |                               |  |
| XO        | leath certifi<br>attending<br>I for use as  |               | IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Fetal death  | 3 ☐Ectopic pregnancy   |                  |  | 23d. Date of del              |  |
|           | v requires that the death cert<br>been signed by the attendin<br>should be detached for use   | Physician/M   | in the past 12 months?  1 Yes 2 No 9 Unknown  4 Pregnant at time of death 9 Unknown   | 5 Other (specify)  |                  |  | Month                         | Day Year   |
| ds, r     | es that<br>gned b   | by PI         | Part II. Other significant conditions contributing to death but not resulting in  | n the underlying cause given in  | Part I.          | 23e. Did tobac                         |                               | the cause of death?                              |
|           | w require<br>been si<br>should  | ted           | Myocardial Interet  | 107  |                  | 1 Tes                                  | 200 3 □ Pr                    | robably 4 Unknown                                |
| T<br>E    | The law requires that the death certif<br>ate hes been signed by the attending<br>page 2 should be detached for use a   | Completed     |   |  |                  | 24a. Was an autopsy performed          | prior to death?               | utopsy findings available completion of cause of |
| <u>a</u>  | cian:<br>ertifica<br>ector, p   | Bec           | 25. Was case referred to medical examiner?  |  | Place of Death   | (Check only one)                       |                               |  |
| 5         | Physi<br>this c   | 70            |   |  |                  | ne 5 Residenc                          | e 6 Other (Spe                | cify)  |
| 0         | ding<br>th:<br>After<br>funer   | tion          |   | Fime of njury at Work?  M 28c. Injury at Work?  1 ☐ Yes                                    |                  | od. Doscribo now                       | injury occurred               |  |
| JIVISION  | or Atter<br>after dea<br>Director<br>in by the  | ertification: | 3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, fa building, etc. (Specify)   | rm, street, factory, office  | 2                | 8f. Location (Stree<br>City or Town, S | et and Number or Re<br>State) | ural Route Number,                               |
| _         | To the Hospital or Attending Physician: The law within 24 bouts after death. To the Funeral Director Atter this certificate hes completely filled in by the funeral director, page 2. | edicai Ce     | 29a. Certifier Check only 2 Medical Examiner: On the basis of examination an  |  |                  |  |                               |  |
|           | To the Pwithin 2-   | Med           | one) and manner stated.  29b. Signature and title of certifier  | 29c. License nur   |                  |  | Date signed (Mor/t            |  |
|           |   |               | Me Mo   | D551   | 8 +              | 1,                                     | 2/6/                          | 05   |
|           |   |               | 30. Name and address of person who completed cause of death (Item 23a)  | (Type, Print) Ann  | e Ar.            | -note                                  | 1-dica                        | (enter   |
|           | Sta<br>Registr  |               | DEC 0 8 2005  31. Date filed (Month, Day, Year)  DEC 0 8 2005   | Sport  |                  | ,                                      |                               |  |

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** Month Day Year ETHEL LAVANIA EADER DEC 2005 6:01 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner SHADY GROVE ADVENTIST HOSPITAL ROCKVILLE MONTGOMERY | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | OCT | 14 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1918 1 □ M 2 K F 214-30-0530 87 Yrs. Director MD Usual Residence of Decedent with the Maryland 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits or 28e-f ehow the Medical Examiner must be natified at MD 1 ☐ Yes 2 No MONTGOMERY POOLESVILLE Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 14931 SUGARLAND ROAD 20837 23a USA filed within 72 hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married ò Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No ρ Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry other then Elementary/Secondary (0-12) College (1-4or 5+) WAITRESS FOOD SERVICE 9 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental Pages 1 and 2 should be EUGENE COLEMAN MAMIE SELBY 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 0 8 3 7 19a. Informant's Name/Relationship (Type, Print) tof Health : 14931 SUGARLAND RD., POOLESVILLE, MD CHARLES EADER / SPOUSE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages I Department of H Important: If its any injury or ot 2005. Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) MONOCACY CEMETERY 12/12/05 BEALLSVILLE, MD 21. Signature of Fineral Service Licensee 22. Name and Address of Facility HILTON FUNERAL HOME 20838 P.O. BOX 86, BARNESVILLE, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** PERITONITIS 3 WEEKS /Medical Due to (or as a consequence of): Examiner SEPSIS WEEKS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) To the Hospitel or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) o 9 Unknown 9 Unknown Division of Vital Records, P. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2/ No 1 🗌 Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an certificate 20 No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: မ 1 Inpatient 2 ER/Outpatient 3 DOA Director: After thi 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification; 28b. Time of 28d. Describe how injury occurred 5 Pending investigation death. 1 Tyes 2 No 2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a Letifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) M 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HAKIM MORSLI, MD 9901 MEDICAL CENTER DR., ROCKVILLE, MD 32. Registrar's Signature 31. Date filed (Month, Day, Year) State DEC 1 2 2005 Registrar

|                                |  |                               | 1 - State of Maryland Registrar  | / Depa                               |                           | of H                   | ealth ar      |                |                                   | C U U 3                                   | G.              | 1587   |
|--------------------------------|--|-------------------------------|--|--------------------------------------|---------------------------|------------------------|---------------|----------------|-----------------------------------|---|-----------------|--|
|                                | Physici<br>/Medic<br>Examin  | al                            | Decedent's Name (First, Middle, Last)  ROBERT LOCKE FLETCHER      4a. Facility Name (If not institution, give street and number)   |                                      | 4b. City,                 | Town, or               | Location of ( | мо<br>1        | e of Death<br>nth<br>2 18         | Day Y<br>2005<br>4c. County of            | ear<br>Death    | 3. Time of Death 2:45a                             |
|                                | Funeral<br>Director  |                               | Civista Medical Center  5. Social Security Number  6. Sex YAM $2\Box$ F  63  Usual Residence of Decedent   | t birthday)<br>Yrs.                  | If Under<br>Months        | LaP1<br>1 Year<br>Days | If Under 24   | Min. (Mo       | e of Birth<br>onth, Day, Ye       | Char<br>9ar) 9                            | Birthpi<br>Coun | lace (State or Foreign<br>try)<br>H • , DC         |
|                                | within 72 hours after death with the Maryland ene. than "natural", or itams 23e or 28e-f show the Modical Examiner must be notified at   | ector                         | 10a. State 10b. County 10c. City, T  | Town or Loc                          |                           | Code                   |               |                | 100                               | . Citizen of Wha                          |                 | 0d. Inside City Limits 1 ☐ Yes 2 ☒No               |
|                                | heath with   | erai Dir                      | 4140 OLD WASHINGTON ROAD  11. Marital Status 12. Was Decedent Ever in U.S.   | 13. V                                |                           | 206                    |               | n? (Specify Ye |                                   | U · S                                     | Α.              |  |
| 900                            | nours after oural; or itan   | d by Fur                      | 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:   | 1                                    | ☐ Yes 2                   | No                     | Specify:      | Puerto Rican,  |                                   | Black, Specify:                           | WH              | ITE  |
| 21215-                         | d within 72 h<br>giene.<br>ar than "nate<br>the Madica   | Completed by Funeral Director | (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)  | 16a. Deced<br>(Give )<br>life. L     | kind of wor<br>OO NOT us  | k done a               | luring most o | f working      |                                   | c. Kind of Busin                          |                 | ,  |
| yland                          | 12 should be filed within and Mental Hygiene. 7 is marked other than "reumatic event, the Mad  | To Be C                       | 17. Father's Name (First, Middle, Last) PEYTON FLETCHER  |                                      |                           |                        | GLAD          | YS FL          | ЕТСНЕ                             |   |                 |  |
| re, Mai                        | s 1 and 2 st<br>of Health and<br>item 27 is n<br>other traun   |                               | JEAN TIERNEY-POA  20a. Method of Disposition  20b. Place communication   |                                      | O CE                      | DAR                    | FORE          |                | .,BRA                             | ity or Town, Standard III  LOCATION - Cit | JE,             | MD 20613   |
| Baltimore, Maryland 21215-0036 | permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or itams 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 20ce.   |                               | 1 □ Burial 2 □ Cremation 3 □ Removal from State  1 □ Donation 5 □ Other (Specify)  | MEM (                                | ORIA<br>. Name and        | L G                    | DNS 1         |                |                                   | LDORF                                     |                 | RYLAND   |
|                                | Physician  |                               | 23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line.  Immediate Cause (final disease or condition                 | X                                    |                           |                        |               |                |                                   |   |                 | Approximate<br>Interval Between<br>Onset and Death |
| 18760, <                       | Attanding Physician: The law requires that the death certificate be executed reasth.  r death.  soctor: After this certificate has been signed by the attending physician and soctor. After this certificate has been signed by the attending physician and soctor the funeral director, page 2 should be detached for use as the burial-transit | dicai Examiner                | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence).      | nce of):                             |                           |                        |               |                |                                   |   |                 |  |
| P.O. Box 68                    | that the death certific<br>ed by the attending p<br>detached for use as  | Physician/Med                 | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  23c. If yes, outcome of pregnanc 1 □ Live birth 2 □ Fetal de 4 □ Pregnant at time of deat 9 □ Unknown | eath 3 🗆                             | Ectopic pre<br>Other (spe |                        |               |                |                                   | 23d. Date o<br>Month                      |                 | ry<br>Day Year                                     |
| Records, P                     | w requires that<br>been signed b<br>should be deta   | by                            | Part II. Other significant conditions contributing to death but not resulting  | ng in the un                         |                           | _                      | n in Part I.  | 23             |                                   |   |                 | e cause of death?                                  |
|                                | ysician: The law r<br>is certilicate has be<br>director, page 2 sh   | Completed                     | CARDIOMYOPATHY   |                                      |                           |                        |               | 1              | a. Was an autopsy performed Yes 2 | prio<br>dea                               | r to con<br>th? | osy findings available inpletion of cause of 2 No  |
| Division of Vital              | anding Physicial<br>lath.<br>or: After this certi<br>ne funeral directo  | ation: To Be                  | 27. Manner of Death  1 Natural 5 Pending (Month, Day Year)  2 Accident investigation   | VOutpatient<br>Bb. Time of<br>Injury |                           | Bc. Injury<br>Work     | at Nursi      | 28d. De        | Residenc                          | e 6 ∐Other (<br>injury occurred           | Specify         | )  |
| Divis                          | To the Hospital or Attano<br>within 24 hours after death<br>To the Funaral Director:<br>completely filled in by the  | il Certification:             | 3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home building, etc. (Specify)  29a. Certifier 1 Certifying Physician: To the best of my knowle                        |                                      |                           |                        | o data and s  | City           | y or Town, S                      | itate)                                    |                 | Route Number,                                      |
|                                | To the Hos<br>within 24 h<br>To the Fun<br>completely  | Medical                       | (Check only 2 Medical Examiner: On the basis of examination one)  2 Medical Examiner: On the basis of examination and manner stated.   | and/or inv                           | estigation,               | in my op               | inion, death  | occurred at th | e time, date                      | and place, and                            | due to          | the cause(s)                                       |
| 1                              | - 3 - 3  |                               | 1 / Lolan  | n-\                                  |                           | D444                   |               |                | _                                 | ec 1                                      | 8               | 2005   |
|                                | 6  |                               | 30. Name and address of person who completed cause of death (Item 2:  Ashvin J Patel MD 102 Paul Me  31. Date filed (Month, Day, Year) 32. Fistrar's Signatur,                                 | ellon                                | Cour                      | t, S                   | uite 1        | 102 Wal        | dorf,                             | MD 206                                    | 02              |  |
|                                | Sta<br>Registr   |                               | 31. Date filed (Month, Day, Year)  DEC 2 3 2005  32. Figistrar's Signatur  | K A                                  | mark                      | 9                      |               |                |                                   | ,   | ,               |  |

|              |  |                   | 1 = For State Registrar  | State                                     | of Marylan                            |                        | artment of F                              |                             |                                  |                               | ene                        | 5 4   | 158                           | 38                 |
|--------------|--|-------------------|--|---|---------------------------------------|------------------------|---|-----------------------------|----------------------------------|-------------------------------|----------------------------|---|-------------------------------|--------------------|
|              |  |                   | 1. Decedent's Name (First, Middl   | e, Last)                                  |                                       |                        |   |                             |                                  | Date of Death<br>Month        |                            | V   | 3. Time of                    | Death              |
|              | Physici<br>/Medic  |                   | Antoinette Smi   | th Fansle                                 | er                                    |                        |   |                             |                                  | ecember                       | •                          | Year<br>005                                     | 12:35                         | РМ                 |
|              | Examin   |                   | 4a. Facility Name (If not institution  | n, give street and n                      | umber)                                |                        | 4b. City, Town, o                         | r Location o                |                                  |                               | 4c. County of              | f Death   |                               |                    |
|              |  |                   | Homewood Retir   |   | T                                     |                        | Willia                                    |                             |                                  |                               | Washi                      |   |                               |                    |
|              | Funeral  |                   | 5. Social Security Number  | 6. Sex<br>1 ☐ M 2 ☑ F                     | 7. Age (In yrs. 92                    | last birthday)<br>Yrs. | Months Days                               | If Under<br>Hours           | Min.                             | Date of Birth<br>(Month, Day, | Year)                      | 9. Birthpla<br>Countr                           | ce (State of<br>y)<br>ipine:  | r Foreign          |
|              | Director   |                   | 218-22-0091 Usual Residence of Decedent  |   | 32                                    |                        |   |                             | L No                             | ov.13,                        | 1913                       | 11111   | ipine:                        | 5                  |
|              | yland  |                   | 10a. State 10b. County   |   | 10c. Cit                              | y, Town or Lo          | cation                                    |                             |                                  |                               |                            | 100   | d. Inside Cit                 | y Limits           |
|              | B Mar  | ctor              | Maryland Balt  | imore                                     | Ca                                    | tonsvi                 | lle                                       |                             |                                  |                               |                            |   | 1X Yes                        | 2 No               |
|              | or 26  | Dire              | 10e. Street and Number   |   |                                       |                        | 10f. Zip Code                             |                             |                                  | 10                            | g. Citizen of Wh           | nat Countr                                      | y?                            |                    |
|              | ath w  | ra                | 719 Maidenchoid  |   |                                       |                        | 21228                                     |                             |                                  |                               | USA                        |   |                               |                    |
|              | ltem<br>Item   | Funeral Director  | 11. Marital Status  1 ☐ Never Married 2 ☐ Mar                                    | Armed F                                   | cedent Ever in U.<br>orces?<br>2 🔯 No | .S.   13.              | Was Decedent of H<br>If Yes, specify Cuba | lispanic Ori<br>an, Mexican | igin? (Specify<br>n, Puerto Rica | / Yes or No-<br>an, etc.)     |                            | <ul> <li>American</li> <li>White, et</li> </ul> |                               |                    |
| 336          | urs aff  |                   | 3 ₩ Widowed 4 Divorced   | If Yes, G                                 | ive '                                 |                        | 1 ☐ Yes 2 No                              | Specify:                    |                                  |                               | Specify:                   | Whit  | ·e                            |                    |
| 21215-0036   | 72 hours after death with the Maryland<br>naturel; or Items 23a or 28a-f show<br>Jical Exacil art mart be notified at  | Completed by      |  | nt's Education                            |                                       | 16a. Dece              | dent's Usual Occup                        | ation                       |                                  | 1-                            | 6b. Kind of Bus            | iness/Indu                                      | stry                          |                    |
| 215          | thin 7   | aldı              | (Specify only higher<br>Elementary/Secondary (0-12)                              |   | (1-4or 5+)                            |                        | kind of work done<br>DO NOT use retired   | auring mosi<br>a)           | t of working                     |                               |                            |   |                               |                    |
| 21           | ed wi<br>ygjen<br>yer th   | Coll              | 12   |   |                                       | Hous                   | ewife                                     |                             |                                  |                               | Domest                     |   |                               |                    |
| Maryland     | be fill<br>ad ott  | Be                | 17. Father's Name (First, Middle,  | Last)                                     | 0                                     |                        |   |                             |                                  | irst, Middle, M               | aiden Sumame,              |   |                               |                    |
| Ž            | d Mer<br>d Mer<br>narke  | 2                 | Allen 19a. Informant's Name/Relations  | thin (Tuna Print)                         | Smith                                 | 10b Mailie             | ng Address (Street                        | Anto                        |                                  | nuta Alumbar                  | Kris                       |   | la dal                        |                    |
| Ma           | d 2 s<br>th an<br>t7 is r<br>traur   |                   |  |   |                                       | 1                      | 9399886                                   |                             |                                  |                               | T. GERMANNAMY              | tate, zip C                                     | ,000                          |                    |
|              | Heal<br>Heal<br>tem 2  |                   | John S. Fansie 20a. Method of Disposition  | r = 3011                                  | 20b. P                                | lace of Dispo          | Box 1004 sition (Name of                  |                             | Date                             | COWE, WV                      | 25414<br>0c. Location - C  | ity or Tow                                      | n, State                      |                    |
| 9            | Pages<br>ent of<br>nt: If i  |                   | 1 Burial 2 Cremation 4 Donation 5 Other (S                                       | 3 □Removal from                           | i State                               |                        | natory or other place<br>ng Cremat        | ·                           | 2-13-2                           | 2005                          | m i the electric           | 11-   |                               | . I                |
| Baltimore,   | permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Menial Hygiene. Important: if item 27 is marked other than "naturel; or items 23a or 28a-f show any injury or other traumatic evant, the Medical Exactinatinative multipled at once.   |                   | 21. Signatur   |   | Jili                                  | 22                     | 2. Name and Addre                         | ss of Facilit               | bs. r                            |                               |                            |   |                               | 10                 |
| ä            | Departing Department of the procession of the pr |                   | Mufola   | " Ohl-                                    |                                       | 4                      | 25 S.Cono                                 | coche                       |                                  |                               | eral Ho                    |   |                               | 705                |
|              |  |                   | 23a. Part1. Enter the disease, or shock, or heart failure. List                  | r complications that<br>only one cause on | caused the deatl                      | h. Do not ent          | er the mode of dyin                       | ng, such as                 | cardiac or re                    | spiratory arres               | st,                        | _ A   | Approximate<br>nterval Betv   | 9                  |
|              | Physician  |                   | Immediate Cause (Final disease or condition                                      |   | orat                                  | 2100                   |   |                             |                                  |                               |                            | 2   | Onset and D                   | eath               |
|              | /Medical<br>Examiner   |                   | resulting in death)  |   | (or as a conseq                       | uence of):             | preu                                      | -1-1-1-01                   | 1100                             |                               |                            |   | <u> </u>                      |                    |
|              | Lxammer  |                   | Sequentially list conditions,  |   | rebro                                 |                        | ular                                      | dis                         | rase                             |                               |                            | y   | ear                           | S                  |
|              | ed sit   | Examiner          | cause. Enter Underlying<br>Cause (Disease or injury                              | Due to                                    | i (or as a cons⊯qi                    | neuce off.             |   |                             |                                  |                               |                            | -1.   |                               |                    |
|              | al-trar  | xan               | that initiated events resulting in death) Last                                   | c   | (or as a conseq                       | uence of):             |   |                             |                                  |                               |                            |   |                               |                    |
| 8760,        | ate be executed<br>hysician and<br>the burial-transit  | alE               |  |   |                                       |                        |   |                             |                                  |                               |                            |   |                               |                    |
| 89           | death certificate be executed<br>e attending physician and<br>d for use as the burial-transit  | Physician/Medical |  | 0.  |                                       |                        |   |                             |                                  |                               |                            |   |                               |                    |
| Вох          | death certifica<br>attending ph<br>d for use as t  | M/u               | IF FEMALE:<br>23b. Was decedent pregnant   |   | utcome of pregna                      |                        | 75.****                                   |                             |                                  |                               | 23d. Date                  | of delivery                                     | ,                             |                    |
|              |  | sicia             | in the past 12 months?<br>1 □ Yes 2 ☑ No   |   | birth 2 □ Feta<br>nant at time of d   |                        | Ectopic pregnancy Other (specify)         |                             |                                  |                               | Monti                      | h D   | ay Y                          | ear                |
| P.O.         | at the de<br>by the<br>stached   | hys               | 9 Unknown  |   |                                       |                        |   |                             |                                  |                               |                            |   |                               |                    |
| Ś            | requires that the<br>een signed by th<br>nould be detache  |                   | Part II. Other significant conditi   |   | death but not res                     | ulting in the u        | nderlying cause giv                       | en in Part I.               |                                  |                               | acco use contrib           |   |                               |                    |
| orc          | w require<br>been sli<br>should b  | ted               | Spinal Mi.   | thritis                                   |                                       |                        |   |                             |                                  | 1 🗆 Yes                       | 2 <b>□</b> No 3            | Probac  | oly 4 🗆 U                     | лкпоwп             |
| ec           | e law<br>has b   | Completed by      | Osteoporos   | SIS                                       |                                       |                        |   |                             |                                  | 24a. Was an autopsy           | prie                       | or to comp                                      | y findings a<br>pletion of ca | vailable<br>use of |
| Vital Record | Th<br>ate<br>pag   |                   |  | Matio                                     | 2                                     |                        |   |                             |                                  | performe                      | No 1                       | ath?<br>□Yes 2                                  | □No                           |                    |
| Z.           |  | Be                | 25. Was case referred to medica examiner?  | Hospitali                                 |                                       |                        | oth Oth                                   |                             |                                  | heck only one                 |                            |   |                               |                    |
| ō            | Pliya<br>r this<br>ral dii   | 0                 | 1 Yes 2 No   | 1 1 1                                     | Inpatient 2  of Injury                | 28b. Time of           | IL 3 DOX                                  | 4 (Buan                     |                                  |                               | ice 6 Other                |   |                               |                    |
| Division     | Attending Plir death. actor: After the yether the funeral  | tlor              | 1 Augural 5 Pendir<br>2 Accident investi   | .9  | of Injury<br>nth, Day Year)           | Injury                 | Wor                                       | k?<br>Yes 2⊡!               |                                  |                               | ,,                         |   |                               |                    |
| Visi         | or Attendi<br>after death.<br>Diractor: A<br>in by the fu  | ifica             | 3 Suicide 6 Could<br>4 Homicide determ   | not be 28e. Place                         | e of Injury - At ho                   | ome, farm, str         | eet, factory, office                      |                             | 28f.                             | Location (Stre                | et and Number              | or Rural F                                      | Route Numb                    | ner,               |
| ā            | spital or Al<br>ours after o<br>leral Dirac<br>filled in by  | Certification:    | 4 🗀 Homicide   | Dulk                                      | aing, etc. (Specii)                   | y)                     |   |                             |                                  | City or Town,                 | State)                     |   |                               |                    |
|              | Hospital<br>1 hours a<br>uneral l  | edical (          | 29a. Certifier 1 Certifyii   | ng Physician: To the<br>Examiner: On the  | e best of my kno                      | wledge, death          | n occurred at the tin                     | ne, date an                 | d place, and                     | due to the cau                | use(s) and mann            | ner as stat                                     | ed.                           |                    |
|              | To the Hos<br>within 24 h<br>To the Fur<br>completely  | Aedi              | one)   | and ma                                    | nner stated.                          |                        |   |                             |                                  |                               |                            |   |                               |                    |
|              | or Neith   | Σ                 | 29b. Signature and title of certifie   | 1   | _ 6_                                  | Q                      | 29c. Licens                               |                             |                                  |                               | d. Date signed (<br>さくさからも |   |                               | 55                 |
| 6            | JP ~   |                   | Cynthia 1  |   |                                       | 1                      |   |                             |                                  |                               |                            |   | •                             |                    |
|              | 8  |                   | 30. Name and address of person   | who completed cau                         | ise of death (Item                    | 1 23a) (Type,<br>42 14 | Print)<br>Paradi                          | se Ch                       | urch f                           | Road 1                        | tagers                     | stow  | n, Mo                         | 2 ryland           |
|              | Sta  | te                | 31. Date filed (Month, Day, Year,  | 1 32.                                     | Biegistrar's Signa                    | iture                  | p   |                             |                                  |                               | ं ञ                        | 1747  | 2                             |                    |
|              | Registr  | ar                | 30. Name and address of person  Cynthia Kutto  31. Date filed (Month, Day, Year, | 2005                                      | Here I                                | 1. Sp                  | all                                       |                             |                                  |                               |                            |   |                               |                    |

05-8555 Unpend item#2a,2/,28a f, pen/E, GS52,2/14/06 IT State of Maryland / Department of Health and Mental Hygiene B.K.S ROBERT J. GROVE 1 - For Stata Registra Certificate of Death Rag. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Month **Physician** Robert Jeffrey GROVE DEC. 2005 18, 0910 A /Medical 4b. City, Town, or Location of Death HAGERSTOWN 4c. County of Death 4a\_Facility Name (If pot institution, give street and number)
WASHINGTON COUNTY HOSPITAL Examiner WASHINGTON 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 1⊠M 2□ F Yrs Director 215-98-3309 Maryland 39 June 9 1966 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 23a or 28a-f ehov the Medical Examiner must be notified at 1X Yes 2 No Maryland Washington Hagerstown Direct 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 629 Picadilly Drive 21740 USA Funeral deeth tems 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 ☐ Yes 2X No If Yes, Give Year or Dates: filed within 72 hours after 1 Never Married 2 Married Maryland 21215-0036 ŏ 1 ☐ Yes 2 No þ Specify: Specify: 3 ☐ Widowed 4 X Divorced \*nature White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 0 Supervisor Telecommunications 27 le marked other r traumatic event, 1 other 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Sumame) 2 should be for and Mental F permit. Pages 1 and 2 should be Department of Health and Mental Important: If Item 27 1e marked 1 any injury or other traumatic even song injury or other ဥ Robert E. Grove Carol Folk 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert E. Grove - Father 401 S. Edgewood Drive, Hagerstown, Md. 21740 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Philos Cemetery 12/21/05 Westernport, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Minnich Funeral Home trut Li Vestal 415 E. Wilson Blvd. Hagerstown, Md. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Narcotic (Methadone) Intoxication and Cocaine use /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Box 68760 Physician/Medicai esn IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy ঠ in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) Division of Vital Records, P.O. detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗷 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ✓ Yes 2 □ No 24a. Was an autopsy performed? page 1**∕** Yes 2□ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) မှ 1 X Yes 2 ☐ No 2 XER/Outpatient 3 DOA this 28a. Date of Injury Fnd (Month, Day Year) 28b. Time of Injury Fnd 28c. Injury at Work? funeral 27. Manner of Death Certification; 28d. Describe how injury occurred After 1 Natural 5 Pending 12/16/05 8:33 death. 2 Accident investigation 1 ☐ Yes 2 No Director: A 6 Could not be determined 3 🗌 Suicide Place of fnjury - At home, farm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) 54 S. Cannon Ave. 4 Homicide within 24 hours after To the Funeral Dire completely filled in b Found in a residence HAgerstown, MD the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E DEC. 19, 2005 and

State Registrar

DHMH 17 Rev 1/2001

DEC 2 3 2005

OPERE MICKIA

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

111 PENN STREET, BALTIMORE, MARYLAND 21201
32. Registrar's Signature

|            |  |                | 1 - For<br>State<br>Registrar                                    |                    | State   | of Maryla                             |                              | artment of F<br>rtificate of                            |                   |              |  | ene<br>g. No. | 15                                | 41590  |
|------------|--|----------------|--|--------------------|---|---------------------------------------|------------------------------|---|-------------------|--------------|--|---------------|-----------------------------------|--|
|            | Division   |                | 1. Decedent's Name   | e (First, Middle   | , Last)                                       |                                       |                              |   |                   |              | 2. Date of Death                             | Day           | Voor                              | 3. Time of Death                                   |
|            | Physici<br>/Medic  |                | Julia F  | 'rancis            | Grant   |                                       | . <u>-</u>                   |   |                   |              | December                                     | . Š, 2        | 005                               | 12:30 p M  |
|            | Examin   |                | 4a. Facility Name (If  | f not institution  | , give street and n                           | umber)                                |                              | 4b. City, Town, o                                       | r Location        | of Death     |  | 4c. Count     | y of Death                        |  |
|            |  |                |  |                    | Greater                                       | · · · · · · · · · · · · · · · · · · · | <del></del>                  | Rockvi  |                   | 2411         |  | Mont          | gomer                             |  |
|            | Funeral Director   |                | 5. Social Security No. 228-16-6                                  | 285                | 6. Sex<br>1 ☐ M 2 🔀 F                         |                                       | s. last birthday)<br>84 Yrs. | If Under 1 Year<br>Months Days                          | If Under<br>Hours | Min.         | 8. Date of Birth<br>(Month, Day,<br>Jan. 21, | Year)<br>1921 | Cou                               |  |
|            | and w  |                | Usual Residence of<br>10a. State                                 | 10b. County        |   | 10c. C                                | City, Town or Lo             | cation  |                   |              |  |               |                                   | Od. Inside City Limits                             |
|            | danyi<br>f ehc   | ŏ              | Maryland   | Montg              | omerv   |                                       | Silver                       | Spring  |                   |              |  |               |                                   | 1 ☐ Yes 2 ☑ No                                     |
|            | the ?  | Director       | 10e. Street and Nun  |                    | J   |                                       |                              | 10f. Zip Code   |                   |              | 10   | g. Citizen of | What Cour                         | ntry?  |
|            | 3e or  |                | 14400 11-  |                    | . D   | W150                                  |                              |   |                   |              |  | •             |                                   | ,  |
|            | ms 2   | Funeral        | 14400 HO   | mecres             | t Road,                                       | cedent Ever in                        |                              | 20906 Was Decedent of H                                 | lispanic Or       | igin? (Spe   | cify Yes or No-                              | 14. Ra        | USA<br>ce - Americ                |  |
| 39         | 72 hours after death with the Maryland<br>"neturel", or items 23e or 28a-f show<br>idical Examinar must be notified at   | by Fur         | 1 ☐ Never Marrie   |                    | Armed f<br>ed 1 ☐ Yes<br>If Yes, G<br>Year or | 2 <b>₹</b> No<br>Sive                 | i                            | f Yes, specify Cuba<br>1 ☐ Yes 2 <b>%</b> No            |                   |              | Rican, etc.)                                 |               | <sub>ck, White,</sub><br>White    |  |
| Ö          | 72 hou   | ted            | <b>(</b> C   | 15. Decedent       | 's Education                                  | 4)                                    | 16a. Dece                    | dent's Usual Occup                                      | ation             | -1-6 - 11    | 1  | 6b. Kind of B | lusiness/In                       | dustry   |
| 21215-0036 | .은 트웰  | Completed      | Elementary/Secon   |                    | College                                       | (1-4or 5+)                            | life.                        | kind of work done<br>DO NOT use retired<br>emaker       | during mos<br>d)  | st of workir | ng   | Own 1         | Home                              |  |
| Maryland 2 | permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If I tam 27 is marked other than any injury or other traumatic event, the MODG. | To Be C        | 17. Father's Name (  |                    | Last)<br>Francis                              |                                       |                              |   |                   |              | (First, Middle, M.                           |               | n <i>e)</i>                       |  |
| ary        | shoul<br>nd M<br>mari  | -              | 19a. Informant's Na  | ame/Relations      | nip (Type, Print)                             |                                       | 19b. Mailir                  | ng Address (Street                                      | and Numb          | er or Rura   | Route Number,                                | City or Town  | , State, Zip                      | Code)  |
|            | nd 2<br>alth a<br>27 is  |                | James Gr   | ant/ S             | on  |                                       | 2711                         | Owens Ro  | oad, 1            | Brook        | eville,                                      | MD 20         | 833                               |  |
| Baltimore, | ages 1 a<br>nt of Hei<br>t: If itam<br>/ or othe   |                |  | Cremation          | 3 □Removal from                               | n State                               | cemetery, crei               | sition (Name of<br>matory or other place<br>n Crematory |                   | Decem        | ber 8,                                       | Oc. Location  | - City or To                      | own, State   |
| Ħ          | artme<br>ortan<br>injun  |                | * 4 □ Donation<br>21. Signature of Fu                            |                    |   |                                       | -                            | ,   |                   |              |  |               | _                                 | Virginia   |
| Ba         | Depar<br>Impor<br>any ir   |                | ) (ii  | when               | Tol   | e                                     | 5                            |   | rsity             | Blvd         | , W, Sil                                     | ver S         |                                   | ,MD 20901  |
|            |  |                |  | n tailure. List    | or mp ications that<br>or ly one cause on     | each ne.                              |                              |   |                   |              |  | t,            |                                   | Approximate<br>Interval Between<br>Onset and Death |
| 8          | Prysician /Medical   |                | Immediate Cause (<br>disease or condition<br>resulting in death) |                    | a   | 1                                     | CER                          | OF  |                   | uN           | 4  |               |                                   | Chook and Dodg.                                    |
|            | Examiner   |                | ,                          |                    | Due to  | o (or as a conse                      | equence of):                 |   |                   |              |  |               |                                   |  |
|            |  | Je.            | Sequentially list cor<br>if any, leading to im                   | mediate            | b. — Due to                                   | o (or as a conse                      | quence of):                  |   |                   |              |  |               | -                                 |  |
|            | uted<br>id<br>ansit  | Examin         | cause. Enter Under<br>Cause (Disease or<br>that initiated events | injury             |   |                                       |                              |   |                   |              |  |               |                                   |  |
| oʻ         | icate be executed<br>physician and<br>s the burial-transit   |                | resulting in death) L  | _ast               | Due to  | o (or as a conse                      | equence of):                 |   |                   |              |  |               |                                   |  |
| 68760,     | ate be<br>hysici<br>he bu  | edical         |  |                    | d   |                                       |                              |   |                   |              |  |               |                                   |  |
| _          | artifica<br>ing pl   |                | IF FEMALE:   |                    |   |                                       |                              |   |                   |              |  |               |                                   |  |
| Box        | death certific<br>attending p  | Physician/M    | 23b. Was decedent<br>in the past 12                              |                    | 1 Live  | utcome of pregr<br>birth 2 Pe         | tal death 3                  | Ectopic pregnancy                                       | /                 |              |  |               | te of delive                      | Day Year   |
| 0.         | t the de<br>by the a<br>tachad f   | yslc           | 1 ☐ Yes 2 ☐<br>9 ☐ Unknown                                       | No                 | 4∐Preg<br>9□Unk                               | gnant at time of<br>nown              | death 5                      | Other (specify) _                                       |                   |              |  | 1             |                                   |  |
| Δ.         | that ti  |                | Part II. Other signifi   | icant conditio     | ns contributing to                            | death but not re                      | sulting in the u             | nderlying cause giv                                     | en in Part I      |              | 23e. Did toba                                | cco use con   | tribute to th                     | e cause of death?                                  |
| Records,   | es<br>g<br>be  | ed by          | _  |                    |   |                                       |                              |   |                   |              | 1 Yes  | 2 🗆 No        | 3 🗌 Prob                          | ably 4 □Unknown                                    |
| 000        | aw requir<br>s been si<br>2 should   | ompleted       |  |                    |   |                                       |                              |   |                   |              | 24a. Was an                                  | 24b.          | Were auto                         | osy findings available                             |
| R          | The lay<br>ate has<br>page 2   | E              |  |                    |   |                                       |                              |   |                   |              | autopsy<br>performe                          | ार्व?         | prior to coi<br>death?<br>1 □ Yes | npletion of cause of                               |
| Vital      |  | Se C           | 25. Was case referr  | red to medical     |   |                                       |                              |   | 26. Place         | of Death     | (Check only one)                             | 2140          | 103                               | 20110  |
| <b>↓</b>   | ys<br>dir  | To B           | examiner?  | No                 | Hospital:                                     | Inpatient 2[                          | ☐ ER/Outpatier               | t 3 DOA Oth   | er: ANU           | irsing Hom   | ne 5 🗆 Residen                               | ce 6 Oth      | ier (Specify                      | ()   |
| n of       |  | E              | 27. Manner of Death  | h<br>5 □ Pendin    |   | e of Injury<br>nth, Day Year)         | 28b. Time or<br>Injury       | 28c. Injun<br>Wor                                       | y at<br>k?        | 2            | 8d. Describe how                             | injury occur  | red                               |  |
| Sio        | Attending r death. sctor: After by the fune  | catle          | 2 Accident   | investig           | ation   |                                       |                              |   | Yes 2             | No           |  |               |                                   |  |
| Division   | in Sir e   | Certification: | 3 ☐ Suicide<br>4 ☐ Homicide                                      | determ             | ined 200. Place                               | ce of Injury - At<br>ding, etc. (Spec | home, farm, str<br>sify)     | eet, factory, office                                    |                   | 2            | 8f. Location (Stre<br>City or Town,          |               | er or Rura                        | l Route Number,                                    |
|            | To the Hospitel or within 24 hours after To the Funerel Dir completely filled in   |                | 29a. Certifier   | Certifyin          | g Physicien: To th                            | ne best of my kr                      | nowledge, deatl              | occurred at the tin                                     | ne, date an       | nd place, a  | nd due to the cau                            | se(s) and ma  | anner as st                       | ated.  |
|            | n 24 ł<br>n 24 ł<br>ne Fu<br>sletely   | edical         | (Check only one)   | 2 Medical          | exeminer: On the and ma                       | nner stated.                          | ation and/or in              | estigation, in my o                                     | pinion, dea       | ith occurre  | d at the time, date                          | e and place,  | and due to                        | the cause(s)                                       |
|            | To the within 2 To the complet   | M              | 29b. Signature and   | title of certifier |   | 4.                                    |                              | 29c. Licens   | e number          | -11          | 290  | I. Date signe | d (Month, I                       | Day, Year)   |
|            | 12/  |                | > 277  | wen                | ball  | MO                                    |                              | 1) 1  | 80 8              | -4           |  | ECEN          | BOR                               | 082005   |
|            | 10   |                | 30. Name and addre   | ess of person      | who completed car                             | use of death (Ite                     | эт 23a) (Туре,               | Print)  | (00)              | & R          | D. Rarl                                      | Ville         | 140                               | 0 & 2005<br>20 & 2                                 |
|            | Sta  | te             | 31. Date filed (Mont   | th, Day, Year)     | 32.   | Pegistrar's Sign                      | nature                       | 1.001   | 1100              | ,            | 1.000  |               |                                   |  |
| 1          | Registr  |                |  | DEC 0              | 9 2005  | Explan.                               | St. A                        |   |                   |              |  |               |                                   |  |

JULK GRANT

If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. **Funeral** 1 □ M 2X F Months Days 220-16-3544 81 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10a. State 10c. City, Town or Location 10b. County item 27 la marked other than "natural", or Items 23a or 28a-f ahow other traumatic event, It's Medical Evarinal must be multified at Director MARYLAND WASHINGTON KEEDYSVILLE 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 19407 PORTERSTOWN ROAD 21756 Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER 17. Father's Name (First, Middle, Last) Be SAMUEL HUTZELL 19a. Informant's Name/Relationship (Type, Print) item 27 I STEPHEN HUTZELL, SON P.O. BOX 1039 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date Department of h Important: If ite any injury or ot once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) BOONSBORO CEMETERY 12/15/2005 21. Signature of Fund Service Licensee 22. Name and Address of Facility 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Lung disease or condition resulting in death) Cenco /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) signed by the a Id be detached f 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. à Completed certificate To the Hospital or Attending Physician: : After this certifical funeral director, r 25. Was case referred to medical Be examiner? 2 No Certification: To 1 Tyes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b Time of 28c. Injury at Work? 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation М 2 Accident within 24 hours after death Fo the Funeral Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

16b. Kind of Business/Industry HOME 18. Mother's Name (First, Middle, Maiden Sumame) ADA POFFENBERGER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SHEPHERDSTOWN, WV 25443 20c. Location - City or Town, State BOONSBORO, MARYLAND 7606 OLD NATIONAL PIKE Approximate Interval Between Onset and Death mont 23d. Date of delivery Month Day 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 2 🗆 No 2 1 No 1 Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number 29d, Date signed (Month, Day, Year) 41667 Carrow Rd

State Registrar

DHMH 17 Rev 1/2001

29a. Certifier

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

muchael

1 3 2005

Medical

1 - For Stete Registrar

**Physician** 

/Medical

Examiner

1. Decedent's Name (First, Middle, Last)

4a. Facility Name (If not institution, give street and number)

19407 Porterstown Road

GRIMM

MARGARET GENEVA

5. Social Security Number

State of Maryland / Department of Health and Mental Hygiene Certificate of Death

7. Age (In vrs. last birthday)

Reg. No.

0400<sup>M</sup>

4b. City, Town, or Location of Death

Keedysville

2. Date of Death

3. Time of Death

Day 2005

DECEMBER 12,

4c. County of Death Washington

8. Date of Birth (Month, Day, Year) JUNE 3, 192 Birthplace (State or Foreign Country) Maryland

10d. Inside City Limits 1 ☐ Yes 2X No

U.S.A. 14. Race - American Indian, Black, White, etc.

WHITE

Specify.

BAST FUNERAL HOME BOONSBORO, MARYLAND

26. Place of Death (Check only one)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

McCorneck 11/10 32. Registrar's Signature

Milound Mo

|                   |   | 1              | 1 - For State Amend #26   | State of Marylan<br>per/FH 12/12,   | d / Departmei<br>/ 2005er Wca                        | nt of Health and<br>te of Death                           |   | giene 05                                     | 41592   |
|-------------------|---|----------------|---|---|--|---|---|--|---|
| 8                 | Physicia  | an             | 1. Decedent's Name (First, Middle, Last) WILLIF MAE   | GREEN   |  |   | 2. Date of Dea<br>Month                       | th<br>Day Yea                                | 3. Time of Death                                      |
|                   | /Medic  | al             | WILLIE MAE  4a. Facility Name (If not institution, give s   | treet and number)   | 4b. City   | , Town, or Location of Dea                                | PECEMBE<br>ath                                | 4c. County of De                             |   |
| П                 | LXdiiiii  | 3              | WASHINGTON  |   |  | AGERSTON  |   | WASHIN                                       |   |
|                   | Funeral<br>Director   |                | 5. Social Security Number 6. Sex 248-40-0028 1  | 7. Age (In yrs. 80  | Yrs. If Under Months                                 | Days Hours Mir  |   | Year) 9. B                                   | tirthplace (State or Foreign Country) UTH CAROLINA    |
| 3                 |   |                | Usual Residence of Decedent   |   | v. Town or Location                                  |   | 7-111/2                                       | 1,1723,70                                    |   |
| Manyla            | f show  | jo             | 10a. State 10b. County  Md. Frederic  |   | ederick  |   |   |  | 10d. Inside City Limits 1 ✓ Yes 2 ☐ No                |
| đ<br>đ            | or 28a-f  | Director       | 10e. Street and Number  |   |  | p Code  |   | 10g. Citizen of What                         | Country?  |
| prejude Maniput   | 18 238<br>must b  |                |   | de Broodent Ever in U   |  | 21701   | Specify Ves or No.                            | U.S. 4.                                      | nerican Indian,                                       |
| )<br>}            | De med which is not a base door mit he many is la hygiene. Id other than "naturel", or items 23s or 28s-f shot event, the Medical Esantraer must be notified at   | Funerai        | 11. Marital Status  1 Never Married 2 Marned  | Armed Forces? 1 ☐ Yes 2 ☑ No  |  | edent of Hispanic Origin? (<br>ecify Cuban, Mexican, Pue  | irto Rican, etc.)                             | Black, Wi                                    | hite, etc.  |
| Ind 2 12 1 3-0030 | ture!',   | d by           | 3 Widowed 4 Divorced  | If Yes, Give/<br>Year or Dates:   |  | /   |   | Specify: B                                   |   |
| 2 2               | n "na<br>Medic  | Completed      | (Specify only highest grade   | College (1-4or 5+)  | life. DO NOT   | ork done during most of w<br>use retired)                 | orking  | PRIVATE                                      |   |
| 7                 | lygiene<br>her thu  |                | 6 771   |   | Domes  |   | (Final Adia)                                  | FAMILIE                                      | 55  |
|                   | month of the man willing and Mental Hygiene.  marked other than imalic event, its M   | To Be          | 17. Father's Name (First, Middle, Last)  WILLIE BOY O   | 1   |  | 1 0   | ame (First, Middle,                           |  |   |
| al yie            | if Heelth and Menitem 27 is market other traumatic  | -              | 19a. Informant's Name/Relationship (Typ   | 1 /   |  | s (Street and Number or F                                 | Rural Route Numbe                             | r, City or Town, State                       |   |
| ב ב<br>ני         | Heelth<br>em 27<br>ther tr  |                | JANNIE Barle  20a. Method of Disposition  | /   | 6450 S   |   | Date Date                                     | 20c. Location - City                         | ck Md 2179  |
|                   | nent of int: If it  |                | 1 ☐ Burial 2 ☐ Cremation 3 ☐ R<br>4 ☐ Donation 5 ☐ Other (Specify)  |   | emetery, crematory or                                | other place) Vem , DRC 1                                  | 2,2005  |  |   |
| Dalt              | Department of important: If it end injury or one  |                | 21. Signature of Funeral Service License  | Polleur   | 6AR  | Ind Address of Facility  L. ROLLIA                        | IS FUND                                       | CAL HOME                                     |   |
| Н                 |   |                | 23a. Part1. Enter the disease, or complice shock, or heart failure. List only on                            | cations that caused the deat  | h. Do not enter the mo                               | de of dying, such as cardi                                | ac or respiratory are                         | rest,  | Approximate<br>Interval Between                       |
|                   | hysician<br>/Medical  |                | Immediate Cause (Final disease or condition resulting in death)   | MESSIM  | e Myor   | earded by   | faultun                                       | <u>'</u>                                     | Onset and Death                                       |
|                   | xaminer   | 3              | f.  | Due to (or as a conseq<br>When  |  | Disease   | )   |  | YEARS   |
| 3                 | si is   | iner           | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | Due to (or as a conseq  | (Jence of):  | -1  |   |  | 1   |
| ,                 | n and<br>ial-tran   | Examin         | that initiated events resulting in death) Last  | Due to (or as a conseq  | uence of):   | 7   |   |  | YEARS.  |
| 20,00             | physicien and<br>the burial-transit   | dicai          | L   |   |  |   |   |  |   |
| 0 Y 0             | nding p   | /Mec           | IF FEMALE: 23b. Was decedent pregnant 2   | 3c. If yes, outcome of pregna   |  |   |   | 23d. Date of c                               | telivery  |
|                   | To the propries of Attending Privation. The law equites that the been certificating the house effect details and the propries that the confidence of the completely filled in by the funeral director, page 2 should be detached for use as | Physician/Me   | in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown   | 1 ☐ Live birth 2 ☐ Feta<br>4 ☐ Pregnant at time of d<br>9 ☐ Unknown                 |  |   |   | Month  | Day Year  |
| , i               | gamed be deta   | þ              | Part II. Other significant conditions con   | tributing to death but not res  | ulting in the underlying                             | cause given in Part I.                                    |   |  | to the cause of death?                                |
| colors,           | been s  | Completed      |   |   |  |   | 24a. Was                                      |  | Probably 4 Dunknown                                   |
| ב ב               | te hes<br>age 2   | фшо            |   |   |  |   | autop<br>perfor                               | sy prior t<br>med? death                     | autopsy findings available o completion of cause of ? |
| אונם              | ector, 1  | Be             | 25. Was case referred to medical examiner?  | lospital:   |  |   | eath (Check only o                            |  |   |
| 5                 | r this or   | . To           | 1 ☐ Yes 2 ☑ No  27. Manner of Death   | 28a. Date of Injury   | ER/Outpatient 3 🗆 0                                  | OA Other: 4 Nursing 28c. Injury at Work?                  |   | ence 6 Other (S                              | pecify)   |
| I SIOISIA         | or: Afte  | ation          | 1 Natural 5 ☐ Pending 2 ☐ Accident investigation  | (Month, Day Year)   | Injury<br>M  | Work?<br>1 ☐ Yes 2 ☐ No                                   |   |  |   |
|                   | s efter de<br>el Directo<br>ed in by t  | Certification: | 3 Suicide 6 Could not be<br>4 Homicide determined   | 28e. Place of Injury - At h<br>building, etc. (Special                              | ome, farm, street, factory)                          | ry, office  | 28f. Location (S<br>City or Tow               | Street and Number or<br>m, State)            | Rural Route Number.                                   |
|                   | n 24 hou<br>se Funar  | edicai         | 29a. Certifier 1 Certifying Physics (Check only one) 2 Medical Examination                                  | sician: To the best of my kno<br>ner: On the basis of examina<br>and manner stated. | owledge, death occurre<br>ation and/or investigation | d at the time, date and pla<br>n, in my opinion, death oc | ce, and due to the c<br>curred at the time, o | cause(s) and manner<br>date and place, and d | as stated.<br>ue to the cause(s)                      |
|                   | To the comp   | Me             | 29b. Signature and title of certifier   | (600)   | 2  | 9c. License number  |   | 29d. Date signed (Mo                         | onth, Day, Year)                                      |
|                   | 1   |                | 30. Name and address of person who ad   | moleted cause of death (Iter  | n 23a) (Tuna Print)                                  | V46561  |   | DEC.05,                                      | 2005  |
|                   | 4   |                | BHARAY RADIR  | 1190 MT.  | MONA RO  | M) Hinge  | MITOWN  | no 2   | 1740.   |
|                   | Sta<br>Regist   |                | 31. Date filed (Month, Day, Year) DEC 1   | 2 2005 Signal 2 2005  | ature.   | ade   |   |  |   |

Registrar DHMH 17 Rev 1/2001

State

30. Name and address of person

31. Date filed (Month, Day, Year)

Janua

32. Registrar's Signature

CM 05-08550 Dennis Hymiller

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

| npend | State of Maryland / Department of Health and Menta | l Hygiene∩ ∩ ⊏ | 1. | 11 | T 0 | 1  |
|-------|--|----------------|----|----|-----|----|
| _     | Certificate of Death                               | Reg. No.       | 5  | 1  | J   | E. |

|            |  |                  | Registrar   |                  |   |          |                     | Ce                  | пінсац  | e or L         | Death                                      | Re                                    | g. No.         |                       |  |
|------------|--|------------------|---|------------------|---|----------|---------------------|---------------------|---|----------------|--|---------------------------------------|----------------|-----------------------|--|
|            |  |                  | 1. Decedent's Name                                      | e (First, Midd   | le, Last)                                   |          |                     |                     |   |                |  | 2. Date of Deat                       |                |                       | 3. Time of Death                                   |
|            | Physici<br>/Medio  |                  | Dennis  | s Wayne          | e Hymille                                   | r        |                     |                     |   |                |  | December                              | 18,            | 2005                  | 10:08 A <sup>M</sup>                               |
|            | Examin   | er               | 4a. Facility Name (f                                    | f not institutio | n, give street and n                        | umber)   |                     |                     | 4b. City,   | Town, or       | Location of Death                          |                                       | 4c. Coun       | y of Death            |  |
| 0          |  |                  | 14 Sulliv   | zan Ave          | enue  |          |                     |                     | Wes   | tmin           | ster                                       |                                       | C              | arrol                 | 1  |
| 760        | Funeral<br>Director  | 1 4              | 5. Social Security N<br>218-88-5                        |                  | 6. Sex<br>1 <b>X</b> M 2 ☐ F                | 7. Ag    | e (In yrs. Ia<br>43 | st birthday<br>Yrs. | Months  | 1 Year<br>Days | If Under 24 Hrs.<br>Hours Min.             | 8. Date of Birth (Month, Day, May 21, | Year)<br>1962  | Cour                  | place (State or Foreign<br>htry)<br>vland          |
| 9          | D  |                  | Usual Residence of                                      |                  |   |          |                     |                     |   |                | ·  |                                       |                |                       |  |
|            | ylan   |                  | 10a. State  | 10b. County      |   |          | 10c. City,          | Town or L           | ocation   |                |  |                                       |                | 1                     | 0d. Inside City Limits                             |
|            | atier death with the Maryland<br>or itema 23s or 28s-1 ehow<br>criter mast te notified at      | Funeral Director | Maryland  | Cai              | rroll                                       |          |                     |                     | W   | estr           | ninster                                    |                                       |                |                       | 1 ☐ Yes 2 🕱 No                                     |
|            | n th   | ire              | 10e. Street and Nur                                     | mber             |   |          |                     |                     | 10f. Zip  | Code           | 04457                                      | 10                                    | ng. Citizen of | What Cour             | ntry?  |
|            | th wit   | <u>a</u>         | 14 Sulli  | ivan A           | venue                                       |          |                     |                     |   |                | 21157                                      |                                       |                | USA                   |  |
|            | dea dea  | ner              | 11. Marital Status                                      |                  | 12. Was Dec                                 | cedent   | Ever in U.S         | 3. 13.              | Was Deced   | lent of Hi     | ispanic Origin? (Sp<br>in, Mexican, Puerto | ecify Yes or No-                      |                | ice - Americ          |  |
| 9          | or th  | 臣                | 1 Never Marri   | ied 2□ Mai       |   | 201      |                     |                     | 1 ☐ Yes 2   | _              | Specify:                                   | 110411, 010.7                         |                |                       | white  |
| S          | ours<br>Fet,   | d by             | 3 Widowed   | 4 Divorced       | Year or                                     |          |                     |                     | 10 163 2  | INO            | Specify.                                   |                                       | Spec           | ny:                   | wiiice   |
| 5-(        | 72 hours<br>"natural",<br>Micel Exc  | etec             | (Spec   | 15. Deceder      | nt's Education<br>est grade completed       | )        |                     | 16a. Dece<br>(Give  | dent's Usua<br>kind of wor                        | l Occupa       | ation<br>during most of work               | ing                                   | 16b. Kind of I | Business/Inc          | dustry   |
| 21215-0036 | withir<br>ane.<br>then   | Completed        | Elementary/Seco   | ndary (0-12)     | College                                     | (1-4or 5 | 5+)                 | life.               | Truck   |                |  |                                       | Tras           | h Remo                | oval   |
|            | il Hygid<br>other  | Be C             | 17. Father's Name                                       | (First, Middle,  | Last)                                       |          |                     |                     |   |                | 18. Mother's Nam                           |                                       |                | me)                   |  |
| Maryland   | ould be<br>Mental<br>arked o   | To B             | Johi  | n Albe           | rt Hymille                                  | er       |                     |                     |   |                | Leona I                                    | May Earh                              | art            |                       |  |
| a J        | should and Men is marke  |                  | 19a. Informant's Na                                     | ame/Relation:    | ship (Type, Print)                          |          |                     | 19b. Mail           | ing Address                                       | (Street a      | and Number or Run                          | al Route Number,                      | City or Town   | , State, Zip          | Code)  |
|            | 5 € Z ±  |                  | Leona Ma  | ay Hym:          | iller, mo                                   | ther     | :                   | 744                 | old B   | alti           | more Road                                  | d, Westm                              | inster         | , MD :                | 21157  |
| Baltimore  | permit. Pages 1 ar<br>Department of Hea<br>Important: if Item:<br>eny injury or other<br>once. |                  | 20a. Method of Disp<br>1 Burial 2<br>4 Donation         | Cremation        | 3 □Removal from Specify)                    | State    | Cei                 | metery, cre         | osition (Name<br>of the Memory of or<br>on Memory | ther plac      | (e) (10.100                                | B/2005                                | Pink<br>Fink   | - City or To<br>sburg |  |
| Balt       | permit. Departi  |                  | 21. Signature of Fu                                     | ineral Service   | . Su  | L        |                     | > 2                 |   |                | ss of Facility 1                           | Myers-Du<br>Westmin                   |                |                       |  |
|            |  | 1                | 23a. Part1 Enter to<br>shock, or hea<br>Immediate Cause | rt failure. Lis  | r complications that<br>t only one cause on | each lir | ne.                 | 1                   | ter the mod                                       | e of dying     | g, such as cardiac                         |                                       |                |                       | Approximate<br>Interval Between<br>Onset and Death |
|            | Physician /Medical   |                  | disease or condition resulting in death)                | n                |   |          | ions of             |                     | ric Eth   | anoli          | SM .                                       |                                       |                |                       |  |

Examiner

attending physician and for use as the burial-transit

To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

Examiner Be Completed by Physician/Medical cate has been signed by the page 2 should be detached Medical Certification:

| resulting in death)   | a. Complications of Chicago Indian  |                                |   |
|---|---|--------------------------------|---|
| resulting in death)   | Due to (or as a consequence of):  |                                |   |
| Sequentially list conditions,   | b   |                                |   |
| if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events | Due to (or as a consequence of):  |                                |   |
| resulting in death) Last  | Due to (or as a consequence of):  |                                |   |
| IF FEMALE:  |   |                                |   |
| 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown                        | 23c. If yes, outcome of pregnancy  1  |                                | 23d. Date of delivery<br>Month Day Year                                     |
| Part II. Other significant conditio   | ns contributing to death but not resulting in the underlying cause given in Part I. |                                | se contribute to the cause of death?  |
|   |   | 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |

| 25. Was case referred to m                 | nedical                      |  |                                       |                     | 26                                | Place of De                     | ath /Check onl                        | (one)                               |  |                       |  |
|--|------------------------------|--|---------------------------------------|---------------------|-----------------------------------|---------------------------------|---------------------------------------|-------------------------------------|--|-----------------------|--|
| examiner?<br>1∭ Yes 2 □ No                 |                              | Hospital:<br>1 ☐ Inpatient 2 ☐   | ER/Outpatient                         | 3 🗆 DC              | 1 -                               |                                 |                                       |                                     | 6 Other (Specify                           | SCENE                 |  |
| 2 Accident                                 | Pending<br>investigation     | 28a. Date of Injury<br>(Month, Day Year)   | 28b. Time of<br>Injury                | M 2                 | Bc. Injury at<br>Work?<br>1 ☐ Yes | 2  No                           | 28d. Describ                          | e how inju                          | ry occurred                                | ·                     |  |
| 3 Suicide 6 Could not determine            |                              | 28e. Place of Injury - At h<br>building, etc. (Special                                 | ome, farm, stree<br>fy)               | t, factory          | office                            |                                 | 28f. Location<br>City or 7            | (Street ar<br>own, State            | nd Number or Rura.<br>9)                   | l Route Numbe         |  |
| 29a. Certifier 1 Ce<br>(Check only one) Me | ertifying Phy<br>edical Exam | rsician: To the best of my kind<br>iner: On the basis of examina<br>and manner stated. | owledge, death a<br>ation and/or inve | crumad<br>stigation | it the time, o                    | date and place<br>on, death occ | a, and due to the<br>urred at the tim | e causo(s)<br>e, date and           | ) and manner as sti<br>d place, and due to | alou.<br>the cause(s) |  |
| 29b. Signature and title of o              | certifier                    |  |                                       | 290                 | 29c. License number O.C.M.E.      |                                 |                                       | 29d. Date signed (Month, Day, Year) |  |                       |  |
| · famile                                   | Frut                         | tell, MD   |                                       |                     |                                   |                                 |                                       | December 19, 2005                   |  |                       |  |

State Registrar

Pamela E. Southell, 31. Date filed (Month, Day, Year) DEC 2 3 2005

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dimol. F. Smithaell MA 111 Penn Street, Baltimore, Maryland 21201

within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director.

|                            |  |                     | For State Registrar  | State of Maryl  |   | artment of h                                 |   | -                                | giene                                   | 5 41595  |
|----------------------------|--|---------------------|--|---|---|--|---|----------------------------------|---|--|
|                            |  |                     | 1. Decedent's Name (First, Middle, I   | ast)  |   |  |   | 2. Date of De                    |   | 3. Time of Death   |
|                            | Physici<br>/Medio  |                     | Ethel V  | irginia   | Haywar  | -d   |   | Decem                            | ber 5, 200                              | Year 0650 M  |
|                            | Examin   |                     | 4a. Facility Name (If not institution, g   |   | 1107 1111   |  | or Location of Death                        |                                  | 4c. County o                            |  |
| ~                          |  | О                   | Peninsula legio  | nal medical   | Center  | Sal  | isbury                                      |                                  | Wic                                     | omico  |
| 3                          | Funeral  |                     |  |   | yrs. last birthday)                                 | If Under 1 Year<br>Months Days               | If Under 24 Hrs.<br>Hours Min.              | 8. Date of Bir<br>(Month, Da     | th<br>v. Year)                          | Birthplace (State or Foreign Country)                          |
| 6                          | Director   |                     | 220-26-2967  | <sup>1□ M</sup> 2√2 F 77                                  | Yrs.  |  |   | Aug.17                           |   | Md.  |
| K                          | and *  |                     | Usual Residence of Decedent  10a. State 10b. County  | 10c   | . City, Town or Lo                                  | cation                                       |   |                                  |   | 10d. Inside City Limits  |
| (                          | death with the Maryland<br>ims 23a or 28a-f ehow<br>if must be notified at   | ō                   | Md. Wico   |   | Salisbu   |  |   |                                  |   | 1 ☐ Yes 2 ☐ No   |
| 2                          | 28a-i  | by Funeral Director | 10e. Street and Number   | .11100  | Salisbu   | 10f. Zip Code                                |   |                                  | 10g. Citizen of Wi                      | 41   |
| 1                          | with   | ā                   |  |   |   |  |   |                                  |   | iat Country?   |
| 30                         | leath  | era                 | 605 A River  | side dr.  12. Was Decedent Ever                           | in U.S. 13 V  | 21801  |   | necify Yes or No                 | USA<br>14 Bace                          | - American Indian,   |
| $\mathcal{A}$              | If the d   | 표                   | 1 □ Never Married 2 □ Married  | Armed Forces?   | 10.0.   | f Yes, specify Cub                           | lispanic Origin? (Si<br>an, Mexican, Puerto | Rican, etc.)                     | Black                                   | , White, etc.  |
| 3 #                        | hours after<br>tural', or ite  |                     | 3 ☐Widowed 4 ☐ Divorced  | If Yes, Give<br>Year or Dates:                            | 1   | I□Yes 2√2 No                                 | Specify:                                    |                                  | Specify:                                | Black  |
| SS#<br>215-0036            | 2 ho   | Completed           | 15. Decedent's   | Education   | 16a. Deced  | lent's Usual Occup                           | pation                                      |                                  | 16b. Kind of Bus                        | iness/Industry   |
| <b>₩</b>                   | within 72<br>ene.<br>than "na:   | pie                 | (Specify only highest of Elementary/Secondary (0·12)   | College (1-4or 5+)  | (Give   | kind of work done<br>DO NOT use retire       | during most of word<br>d)                   | king                             |   |  |
| 21.                        | d wit  | E C                 | 12   | 11  | Chil  | d Care                                       | Provide                                     | r                                | Day C                                   | are  |
|                            | e filed<br>al Hygi<br>other<br>vent, I   | Be C                | 17. Father's Name (First, Middle, La   | st)   |   |  | 18. Mother's Nam                            | ne (First, Middle,               | Maiden Sumame                           | )  |
| 3 iai                      | should be ind Mental I marked o  | 10                  | Otho Asb   | ury Miles   |   |  | Nettie                                      | Virg                             | inia K                                  | ing  |
| Maryland                   | s 1 and 2 should be filed within 72 hours after death with the Marylan f Health and Mental Hyglene. Item 27 ie marked other than "natural", or Items 23a or 28a-f show other traumalic event, it a Medical Examinating must be notified at               |                     | 19a. Informant's Name/Relationship   | (Type, Print)   | 19b. Mailin   | g Address (Street                            | and Number or Ru                            | ral Route Numbe                  | er, City or Town, S                     | tate, Zip Code)  |
| <b>4</b> -                 | and 2<br>lealth<br>m 27 i  |                     | Fran Starkey   | /Daughter   | 605   | A River                                      | side dr                                     | . Sali                           | sbury,M                                 | d.21801  |
| d S                        | of He  |                     | 20a. Method of Disposition   | 20  | <ul><li>Db. Place of Disposementary, crem</li></ul> | sition (Name of natory or other pla          | ce)   | Date                             |   | City or Town, State  |
| TE                         | Pages<br>nent of<br>ant: If it   |                     | 1 ☐ Burial 2 ☐ Cremation 3<br>4 ☐ Donation 5 ☐ Other (Spec   |   | St.Mark   | s ceme.                                      | 12/1  | 0/05                             | Princes                                 | s Anne,Md.   |
| e) Ha.<br>Baltimore,       | permit. Pages<br>Depertment of<br>Importent: If it<br>eny injury or o  |                     | 21. Sign Jure o Funeral Service Lic  | ensee   | 22  | . Name and Addre                             | ss of Facility Be                           | nnie S                           | mith Fu                                 | neral Home   |
| B                          | 88 = 8   |                     | triscilla  | I Kound.  |   |  |   |                                  |   | y, Md/. 21801  |
| 84he                       |  |                     | 23a. Part1. Enter the disease, or co<br>shock, or heart failure. List on   | implications that caused the c                            | death. Do not ente                                  | er the mode of dyli                          | ng, such as cardiac                         | or respiratory ai                | rest,                                   | Approximate<br>Interval Between                                |
| 3                          | Physician  |                     | Immediate Cause (Final disease or condition  |   | A ( T = =   |  | a No Ea                                     |                                  | 1                                       | Onset and Death  |
|                            | /Medical   |                     | resulting in death)  | a Due to (or as a con                                     |   | 1  | ANCER                                       |                                  |   | 6 MONTHS   |
| - 1                        | Examiner   |                     | Conventially list annulations  | b   |   |  |   |                                  |   |  |
|                            | D ==   | ner                 | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury  | Due to (or as a con                                       | nsequence of):                                      |  |   |                                  |   |  |
|                            | nd   | Examiner            | that initiated events  | c   |   |  |   |                                  |   |  |
| 760,                       | e exe<br>ien a<br>urial-   |                     | resulting in death) Last   | Due to (or as a con                                       | nsequence of):                                      |  |   |                                  |   |  |
| 876                        | Attanding Physician: The law requires that the death certificate be executed in death.  Cleath.  After this certificate has been signed by the ettending physicien and by the funeral director, page 2 should be detached for use as the burial-transit. | lical               | •  | d   |   |  |   |                                  |   |  |
| 9                          | leath certifica<br>ettending ph<br>I for use as th   | Physician/Med       | IF FEMALE:   |   |   |  |   |                                  |   |  |
| Вох                        | ath co   | an/                 | 23b. Was decedent pregnant in the past 12 months?  | 23c. If yes, outcome of pre<br>1☐Live birth 2☐F           | Fetal death 3                                       | Ectopic pregnancy                            | 1   |                                  | 23d. Date<br>Mont                       | of delivery<br>h Day Year                                      |
|                            | at the dea<br>by the e<br>tached fo  | Sici                | 1 ☐ Yes 2 ☑ No<br>9 ☐ Unknown  | 4 Pregnant at time<br>9 Unknown                           | of death 5  | Other (specify)                              |   |                                  | MOH                                     | i Day real   |
| P.0                        | d by   | 5                   |  | and thusing to death but you                              | h manufation in the con-                            |  | - 1. P. 44                                  | 00- Did 4                        |   |  |
| S,                         | res tha<br>signed t  | ב                   | Part II. Other significant conditions  | Contributing to death out not                             | r resulting in the un                               | ideriying cause giv                          | en in Part I.                               |                                  |   | oute to the cause of death?                                    |
| o o                        | v require<br>been si<br>should l   | ted                 |  |   |   |  |   | , , ,                            | res 2   No 3                            | B ☐ Probably 4 ☐ ₩nknown                                       |
| ec                         | law<br>lasb  | nple                |  |   |   |  |   | 24a. Was<br>autop                | an 24b. We                              | ere autopsy findings available<br>or to completion of cause of |
| Division of Vital Records, | The law<br>sete has l<br>page 2 s  | Completed           |  |   |   |  |   | perfo<br>1 ☐ Yes                 | rmea? ae                                | ath?<br>□Yes 2□No  |
| /ita                       | sician: The<br>certificate<br>irector, pag   | Be                  | 25. Was case referred to medical examiner?   |   |   |  | 26. Place of Dear                           |                                  |   |  |
| É                          | Physic<br>this c   | ို                  | 1 ☐ Yes 2 ☐ No   |   | 2 ER/Outpatient                                     | t 3□ DOA Oth                                 | er: 4 Nursing H                             | ome 5 Resid                      | lence 6 Other                           | (Specify)  |
| <u> </u>                   | ding F<br>h.<br>After<br>funera  | e e                 | 27. Manner of Death 1 ☑Naturaf 5 ☐ Pending   | 28a. Date of Injury<br>(Month, Day Yea                    | 28b. Time of fnjury                                 | 28c. Injur<br>Wor                            |   | 28d. Describe h                  | now infury occurred                     | 1  |
| sio                        | tend<br>leath<br>tor: /  | cati                | 2 Accident investigat 3 Suicide 6 Could not  | he  |   |  | Yes 2 □No                                   |                                  |   |  |
| Ξ                          | Z =  | Certification:      | 4 Homicide determine   |   | At home, farm, stre<br>pecify)                      | eet, factory, office                         |   | 28f. Location (S<br>City or Tox  | Street and Number<br>vn, State)         | or Rural Route Number,   |
|                            | To the Hospital of within 24 hours of To the Funeral D completely filled in  |                     | 00-0-0   | <b>2</b>  |   |  |   |                                  |   |  |
|                            | Hos<br>Fun<br>Fun<br>feit f  | Medical             | 29a. Certifier 1 Certifying I (Check only one) 2 Medical Ex  | Physician: To the best of my aminer: On the basis of exam | knowledge, death<br>nination and/or inv             | occurred at the tire<br>restigation, in my o | ne, date and place,<br>pinion, death occur  | and due to the cred at the time, | cause(s) and manr<br>date and place, an | ner as stated.  Id due to the cause(s)                         |
|                            | thin 2<br>the<br>mple  | Med                 | 29b. Signature and title of certifier  | and manner stated.  |   | 29c. Licens                                  | e oumber                                    |                                  | 20d Date signed                         | (Month, Day, Year)   |
|                            | N N N  |                     | •  | 00-   | A   |  | 9/68  |                                  | / > / 6 / C                             |  |
|                            |  |                     | > Pobert a   |   |   |  | 1160  |                                  | , 6                                     |  |
|                            |  |                     | 30. Name and address of person wh  | o completed cause of death (                              | (Item 23a) (Type, I                                 | Print)                                       | -   | A                                |   | 2 . 0 . 16   |
|                            |  |                     | 31. Date filed (Month Day Year)  | 32 Registrarie C  | ignature  | 014/2101                                     | 37. , 5.                                    | MLISBU                           | -T, MD                                  | 21804  |
|                            | Sta<br>Registr   | ar                  | POBERT ALLE 31. Date filed (Month, Day, Year) DEC 0 9  | 2005  | H. Ma   | asket  |   |                                  |   |  |
|                            |  |                     | The Country of the Co | LOUS BARRESS  | July Mary   | ne although.                                 |   |                                  |   |  |

| Physici  |                                | 1. Decedent's Name (First, Middle Hildegard U   |   | =  | ***               |   |   | 2. Date of Deat<br>Month<br>Novembe | Day                        | Year<br>2005  | 3. Time of Death <b>1635</b> M                              |
|--|--------------------------------|---|---|--|-------------------|---|---|-------------------------------------|----------------------------|---|---|
| /Medic<br>Examin   |                                | 4a. Facility Name (If not institution   |   |  | 4b                | . City, Town, o                                     | r Location of Death                         |                                     |                            | y of Death  |   |
| LAGIIII  | Ci                             | Harford Mem   | orial Hospi                             | tal  |                   | Havre   | de Grace                                    |                                     | На                         | rford   |   |
| Funeral  |                                | 5. Social Security Number   | 6. Sex 7. A                             | ge (In yrs. last bir                         |                   | Under 1 Year<br>onths Days                          | If Under 24 Hrs.<br>Hours Min.              | 8. Date of Birth<br>(Month, Day,    | Yearl                      | 9. Birthp   | place (State or Foreign                                     |
| Director   |                                | 220-72-7467   | 1□M 2∏F                                 | 75   | Yrs.              | ontais Days   | Tiodis Will.                                | May 20,                             |                            | Pola  |   |
| 450  |                                | Usual Residence of Decedent   |   | 10. O'b. T.                                  |                   |   |   |                                     |                            | 1.  | Od Inside City Limite                                       |
| ms 23a or 28a-f show   | _                              | 10a, State 10b. County  |   | 10c. City, Tow                               |                   |   |   |                                     |                            | Ι,  | 10d. Inside City Limits 1 ☐ Yes 2 ☑ No                      |
| 3a-f s   | Director                       | MD Harf   | ord                                     | Ha   | vre d             | e Grace   | e   |                                     |                            |   |   |
| or 28  | Oire                           | 10e. Street and Number  |   |  | 1                 | Of, Zip Code  |   | 1                                   | German<br>German           | What Cour   | ntry?   |
| 23a  | rai                            | 33 Telestar Wa  |   |  |                   |   | 21078                                       |                                     |                            | <del>JSA</del>  |   |
| "natural", or items 23a<br>sulcal Examiner roust t   | by Funerai                     | 11. Marital Status  | 12. Was Decedent<br>Armed Forces        | ?  | 13. Was           | Decedent of I-<br>s, specify Cub                    | lispanic Origin? (St<br>an, Mexican, Puerto | pecify Yes or No-<br>p Rican, etc.) |                            | ice - Americ<br>ack, White,                             |   |
| 0 5  | Y.                             | 1 Never Married 2 Marr  | If Yes, Give                            |  | 10                | Yes 2∰ No   | Specify:                                    |                                     | Spec                       | ify: wh   | nite  |
| IEX  |                                | 3 Widowed 4 Divorced  | Year or Dates:                          |  | December 1        |   |   |                                     | 10h Kind of I              |   |   |
| nar  | Completed                      | 15. Decedent<br>(Specify only highes  | is Education<br>at grade completed)     | 16a  | (Give kind        | s Usual Occup<br>of work done<br>VOT use retire     | during most of work                         |                                     | 16b. Kind of I             | business/in   | dustry  |
| han<br>M   | m<br>d                         | Elementary/Secondary (0-12)   | College (1-4or                          | 5+)  |                   |   | ۵)  |                                     |                            |   |   |
| nt, II   | ပိ                             | 17. Father's Name (First, Middle,   | l ast)                                  |  | home              | maker   | 18. Mother's Nam                            | ne (First, Middle, I                | own h                      |   |   |
| eve  | Be                             |   |   |  |                   |   |   |                                     |                            |   |   |
| nark   | P_C                            | Alfred Neuman  19a. Informant's Name/Relations  |   | 101  | h Mailing A       | ddenn /Stront                                       | and Number or Ru                            | ka Wydra                            |                            | n State Zie   | Codel   |
| n and Mental Hyglerie. 7 is marked other than "I raumatic event, the Men   |                                |   |   |  |                   |   |   |                                     |                            |   | _   |
| The parties are marked other than "natural", or items 23a or 28a-1 abov<br>or other traumatic event, the Maulcal Examinations is be notified at                  |                                | Rudi Holzinge  20a. Method of Disposition   | r/spouse                                | 20b. Place o                                 |                   |   | Way Havre                                   |                                     | 20c. Location              | 2107  |   |
| nnt: If Ite<br>iny or ot   |                                | 1 ☐ Burial 2 ☐ Cremation  | 3 □Removal from State                   | cemete                                       |                   | ry or other pla                                     | ce)   |                                     | 200. Eduation              | olly of 10  | JWII, JIUIO   |
| ury  |                                | ` 4 ∑Donation 5 ☐ Other (S  |   |  |                   |   | 1   |                                     |                            |   |   |
| Important: If I<br>any injury or<br>once.  |                                | 21. Signature of Funeral Service Ronald   | Wade Date                               | ector  |                   |   | oss of Facility<br>Omy Board<br>MD 2120     |                                     | Baltin                     | nore S  | treet   |
| pysician<br>Medical<br>kaminer<br>purial-Itausit   | ai Examiner                    | 23a. Part Enter the disease or shock or heart failure. List Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | a. No N Due to (or a b. Due to (or a c. | line.  | of):              |   | LUNG  |                                     |                            |   | Interval Between Onset and Death Q MINOTH                   |
| be detached for use as the   | Completed by Physician/Medical | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown  Part II. Other significant condition   | 4□Pregnant<br>9□Unknown                 | 2 Fetal death                                | 5 🗆 Ot            | opic pregnanc<br>her (specify) _<br>rtying cause gn |   |                                     | Dacco use co               |   | Day Year he cause of death?                                 |
| s ue   | ted                            | TNEUMONIT.  | F 1 21 040872                           | 148  |                   |   |   | 1 U Y                               | s 2 No                     | 3   Prot  | pably 4 Dinknown  |
| ate has  | Comple                         |   |   |  |                   |   |   | 24a. Was a autops perform           | y                          | . Were auto<br>prior to co<br>death?<br>1 \( \text{Yes} | opsy findings available<br>impletion of cause of<br>2000 No |
| certificate  | Be                             | 25. Was case referred to medica examiner?   |   |  |                   |   |   | th (Check only or                   | (8)                        |   |   |
| his c  | 2                              | 1 ☐ Yes 2 No  | Hospital: 1 ☐ Inpa                      |  | utpatient         | 3011  |   | ome 5 Reside                        |                            |   | (y)   |
| fter t   |                                | 27. Manner of Death 1 XNatural 5 ☐ Pendir   | 28a. Date of In<br>(Month, D            | jury 28b.<br>Day Year)                       | Time of<br>Injury | 28c. Inju<br>Wo                                     | ry at<br>irk?                               | 28d. Describe ho                    | ow injury occu             | ırred   |   |
| - < 2  | ati                            | 2 Accident investi  | gation                                  |  | _                 | M 1   | Yes 2 No                                    | *                                   |                            |   |   |
| he he  | ij                             | 3 Suicide 6 Could 4 Homicide determ   | ained 288, Place of I                   | njury - At home, f.<br>etc. <i>(Specify)</i> | arm, street,      | factory, office                                     |   | 28f. Location (Si<br>City or Town   | treet and Nun<br>n, State) | nber or Rure  | al Route Number,  |
| Director:  | ert                            |   | ng Physicien: To the bes                |  |                   |   |   |                                     |                            |   |   |
| 24 hours after death<br>Funeral Director:<br>stely filled in by the  | dical Certification:           |   | Exeminer: On the basis                  | or examination at<br>stated.                 |                   | ,   |   |                                     |                            |   |   |
| the Funeral Director:<br>mpletely filled in by the   | Medical Certif                 | (Check only 2 Medical one)  | Exeminer: On the basis and manner       | stated.                                      |                   | 29c Licen   | se number                                   | 2                                   | 9d. Date sign              | ed (Month,  | Day, Year)  |
| To the Funeral Director:<br>completely filled in by the  | edical                         | (Check only 2 Medical   | Exeminer: On the basis and manner       | stated.                                      |                   | 29c Licen   | se number                                   | 2                                   | 9d. Date sign              | ed (Month,  | Day, Year)  |
| To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifics completely filled in by the funeral director, | edical                         | (Check only 2 Medical one)  | Exeminer: On the basis and manner       | stated.                                      |                   | 29c Licen   |   | 2                                   | 9d. Date sign              | ed (Month,  | Day, Year)  |

DHMH 17 Rev 1/2001

|                            |  |                |   | State of Mary<br>s 24a,26 per  | verb                                      | artment of H                                  | ealth and I<br>V05dhb<br>ealth           |  | <u> </u>  | 41597                                      |
|----------------------------|--|----------------|---|--|---|---|--|--|---|--|
|                            | Physici  | an             | 1. Decedent's Name (First, Middle, Las<br>Fleetwood Alan                                | *  |   |   |  | 2. Date of Deat<br>Month                   | Day Year  | 3. Time of Death                           |
|                            | /Medi  |                |   |  |   |   |  | Dec 18,                                    |   | 15:15 P <sup>M</sup>                       |
| >                          | Examir   | ier            | 4a. Facility Name (If not institution, give   |  |   | 4b. City, Town, or                            |  |  | 4c. County of Death                             |  |
|                            |  |                | Southern Mary 1s  5. Social Security Number 6. So                                       |  |   | Clin  | ton If Under 24 Hrs.                     | 0.5-115-15                                 | Prince G  |  |
|                            | Funeral<br>Director  |                |   | ДМ 2ПЕ   | yrs. last birthday)  Yrs.                 | Months Days                                   | Hours Min.                               | 8. Date of Birth<br>(Month, Day,<br>Nov 27 | , 1935 Mar                                      | place (State or Foreign<br>intry)<br>yland |
|                            | and and  |                | 10a. State 10b. County  | 10   | c. City, Town or Lo                       | cation  |  |  |   | 10d. Inside City Limits                    |
| ,                          | Mary<br>F. Pr  | ō              | Maryland Prince Go  | orgo's   | Unner                                     | Mar1boro                                      |  |  |   | 1 ☐ Yes 2 ☐ No                             |
|                            | 288  | Directo        | 10e. Street and Number  | 201 60 5   | оррсі                                     | 10f. Zip Code                                 |  | 1  | Og. Citizen of What Cou                         |  |
| 3                          | 38 0   |                | 4901 Roblee Dr:   | ive  |   | 207   | 72                                       |  | United Sta                                      | tes  |
|                            | Gaard  | Funeral        | 11. Marital Status  | 12. Was Decedent Eve   |   | Was Decedent of His                           | spanic Origin? (Sp                       | pecify Yes or No-                          | 14. Race - Ameri                                |  |
| Marylarid 212-0030         | permit. Pages 1 and 2 should be lied within 72 hours after death with the maryland Department of Hastly and Mental Hygiene. Department of Hastly and Mental Hygiene. I important: If them 27 is marked other then "natural; or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be notified at ance. | by             | 1 ☐ Never Married   | Armed Forces?<br>1√57/Yes 2 □ No √<br>If Yes, Give<br>Year or Dates:         | 7   | f Yes, specify Cubar<br>1 ☐ Yes 2 ☐ No        | Specify:                                 | Rican, etc.)                               | Black, White                                    | etc.<br>1ack                               |
| 5                          | atur<br>call   | Completed      | 15. Decedent's Ed   |  | 16a, Dece                                 | dent's Usual Occupa                           | ition                                    |  | 16b. Kind of Business/Ir                        |  |
| 7                          | Wed "  | ple            | (Specify only highest gra   | College (1-4or 5+)   | life.                                     | kind of work done d<br>DO NOT use retired;    | uring most of wor<br>)                   | king                                       |   |  |
| 7                          | T the  | Ю              | 12  | 2  | Te  | chnician                                      |  |  | Pathology                                       |  |
| 2                          | oth H  | Be (           | 17. Father's Name (First, Middle, Last)   |  |   |   | 18. Mother's Nam                         | e (First, Middle, M                        | Maiden Sumame)                                  |  |
| 9                          | snould be<br>nd Mental<br>marked o   | 2              | Edgar Henry   |  |   |   | Ada P                                    | inder                                      |   |  |
| <u> </u>                   | and is ma  | m i            | 19a. Informant's Name/Relationship (7   | • •  |   |   |  |  | City or Town, State, Zi,                        | o Code)                                    |
|                            | aalth<br>n 27  |                | Miki A. Henry (W  |  |   |   |  |  | lboro, MD                                       | 20772                                      |
| ָט<br>כ                    | of He  |                | 20a. Method of Disposition 1 ☑Burial 2 ☐ Cremation 3 ☐                                  | Removal from State   | Ob. Place of Dispo<br>cemetery, cren      | sition (Name of natory or other place         | Dec 27,                                  | D2005                                      | 20c. Location - City or T                       | own, State                                 |
| Ě                          | rages<br>nent of l   |                | 4 □ Donation 5 □ Other (Specify   | nomoval mom state  |   | Veterans (                                    | 1  | 1  | Cheltenham,                                     | Maryland                                   |
| Dalilli Ofe,               | Departr<br>Departr<br>Importa<br>any inju  |                | 21. Signature of Funeral Service Licen  | Angue  |   |   |  |  | Home, Inc                                       |  |
| п                          |  |                | 23a. Part1. Enter the disease, or comp  | plications that caused the   |   |   |  |  |   | Approximate                                |
| , F                        | hysician   |                | shock, or heart failure. List only of<br>Immediate Cause (Final<br>disease or condition |  | scles                                     | tic CA  | rdi was                                  | cular                                      | Heart D.  | Interval Between<br>Onset and Death        |
|                            | /Medical   |                | resulting in death)   | Due to (or as a co   |   | 717 - 071                                     | , 4,500                                  | 00-10-0                                    | -00   | , 050                                      |
| ,                          | Examiner   |                | Sequentially list conditions,   | b  |   |   |  |  |   |  |
|                            | g #  | iner           | if any, leading to immediate cause. Enter Underlying                                    | Due to (or as a co   | insequence of):                           |   |  |  |   |  |
|                            | ind<br>trans   | Examin         | Cause (Disease or injury that initiated events resulting in death) Last                 | с  |   |   |  |  |   |  |
| ,<br>2                     | icate be executed<br>physician and<br>s the burial-transit   | û              | Tooding in dodiny cast  | Due to (or as a co   | insequence of):                           |   |  |  |   |  |
| 00700                      | physic<br>the b  | dical          |   | d  |   |   |  |  |   |  |
| 9                          | es mar life death befrincate be executed igned by the attending physician and be detached for use as the burial-transit  |                | IF FEMALE:  | 1 10 000 000   | 5000                                      |   |  |  |   |  |
| Y.O. DOY                   | ttend<br>or us   | Physician/M    | 23b. Was decedent pregnant in the past 12 months?                                       | 23c. If yes, outcome of p<br>1 ☐ Live birth 2 ☐                              | Fetal death 3                             | Ectopic pregnancy                             |  |  | 23d. Date of deliv<br>Month                     | ery<br>Day Year                            |
| 5                          | the a  | /sic           | 1 ☐ Yes 2 ☐ No<br>9 ☐ Unknown   | 4□Pregnant at time<br>9□Unknown  | of death 5                                | Other (specify)                               |  |  | , and the                                       | buy Tour                                   |
|                            | d by<br>fetac  |                | Part II. Other significant conditions of  | antichuting to death but or  | at coculting in the                       |   | a in Deat                                | 02a Didash                                 |   |  |
| Civision of vital necolds, | n signe  | d by           | Partition of Significant Conditions (   | omnouting to death out no  | or resulting in the ur                    | idenying cause give                           | nın Parti.                               |  | s 2 No 3 Prof                                   |  |
| 3                          | been si<br>should I  | Completed      |   |  |   |   |  | 24a. Was ar                                | 24h Wara auto                                   | ppsy findings available                    |
| ב ל                        | a has  | Ĕ              |   |  |   |   |  | autopsy                                    | v prior to co                                   | mpletion of cause of                       |
| 5                          | ificate<br>or, pa  | e C            | 25. Was case referred to medical  |  |   |   |  | perform                                    |   | 2□ No                                      |
| •                          | cert<br>irect  | 00             | examine(?)  | Hospital: 1 Nnpatient  | 0 □ ED/O                                  | Othe  | LA CONTRACTOR PAGE                       | h Check only one                           |   |  |
| 5 8                        | uning Fringsteam, The h. After this certificate he funeral director, paga  | ٠. T           | 27. Manner of Death   | 28a. Date of Injury<br>(Month, Day Ye  | 2 ER/Outpatien                            | t 3∐ DOA<br>28c. Injury                       | 4 LI Nursing Ho                          | ome 5 ☐ Reside<br>28d. Describe ho         | nce 6 Other (Special                            | (y)  |
| 5                          | Tage In  | ţ              | 1 ☐Natural 5 ☐ Pending 2 ☐ Accident investigation                                       |  | ar) Injury                                | Work  | ?<br>'es 2 ☐ No                          |  | in wifely coodings                              |  |
| 2                          | dea<br>ctor<br>y the   | fica           | 3 ☐ Suicide 6 ☐ Could not be  |  | At home, farm, stre                       |   |  | 28f. Location (Str                         | eet and Number or Rura                          | al Route Number                            |
|                            | aftar<br>Dir<br>d in b   | Certification; | 4 Homicide  | building, etc. (S  | pecify)                                   |   |  | City or Town                               | , State)  |  |
|                            | To the hospital or Attending Frightsian. The taw requires that the bearn certain 24 hours affar deports.  Within 24 hours affar decider: Affar this certificate has been signed by the attending completely filled in by the funeral director, paga 2 should be detached for use as  | edicai C       | 29a. Certifier 1 Certifying Physics (Check only one) 2 Medical Example 1                | /sician: To the best of m<br>iner: On the basis of exa<br>and manner stated. | y knowledge, death<br>mination and/or inv | occurred at the time<br>restigation, in my op | e, date and place,<br>inion, death occur | and due to the ca                          | use(s) and manner as site and place, and due to | tated.<br>the cause(s)                     |
|                            | o the  | Me             | 29b. Signature and title of certifier   |  |   | 29c. License                                  | number                                   | 29   | 9d. Date signed (Month,                         | Day, Year)                                 |
| 1                          |  |                | 1 Landon  | Shata  | 120                                       |   |  |  |   |  |
| , 1                        | x,   |                | 30. Name and address of person who  | nlated cause of death  | (Itam 22a) /Tuna                          | Print)  | 35171                                    | 3  | iccent.   | es di, ucos                                |
| 1                          | 0  |                | SALVA Lon Su  |  |   | spital  | Drin                                     | e U  | becent.   | MA   |
|                            | Sta  | te             | 31. Date filed (Month, Day, Year)   | 32. Registrar's  |   | spila   | 0.77                                     | 7  | 7   | ru.  |
|                            | Registr  | _              | DEC 2 3 2005  | la de  | - CP                                      |   |  |  |   |  |

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Marjorie Jarvis Phillips Hewlett December 2, 2005 7:03 ₽<sup>м</sup> /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Anne Arundel Medical Center Anne Arundel Annapolis 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Year) - 1919 1 ☐ M 2 🔀 F 86 New York 578-26-3749 Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits 28e-f show in than "natural", or items 23a or 28e-f show the Medical Examinant must be notified at Yes 2 □ No Prince George's Bowie Maryland Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20720 7303 Quartz Terrace United States death 1 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Importent: If Item 27 is marked other than "natural", or Itel any injury or other treumatic event. The Medical Exami 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: ģ 3℃Widowed 4 □ Divorced African American Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Teacher Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) J. Foster Phillips Bertha Jarvis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7303 Quartz Terrace, Bowie, MD Elizabeth Hewlett (daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State ☐Burial 2 ACremation 3 ☐Removal from State Chesapeake Crematory \* 4 ☐ Donation 5 ☐ Other (Specify) 12/12/05 Beltsville,MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility McGuire Funeral Service 7400 Georgia Ave. N.W., Washington, D.C. 20012 23a. Part 1. Enter the disease, or complications the caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician onuemonia /Medical Due to (or as a consequence of): Examiner resistant staphlococcus acure Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner the attending physicien and ched for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Day Month Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 No 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ anew 15m 1 🗌 Yes 2/1No 3 Probably 4 □Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy perform 2 No 1 Yes or Attending Physicien: after death. | Director: After this certifica 25. Was case referred to medical examiner? 26. Place of Death Check onl one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🗷 Vo 1 Inpatient 2 ER/Outpatient 3 DOA To the Hospitel or Attending Phys within 24 hours after death.

To the Funerel Director: After this completely filled in by the funeral dir 28a. Date o Injury (Month, Day 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D58510 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32 Registrar's Signature State DEC 0 9 2005 Registrar

|            |  | giba .                  | State of Maryland / Department of Health and Certificate of Death  | d Mental Hy                                 | giene                                 | 5 41599  |
|------------|--|-------------------------|--|---|---------------------------------------|--|
|            | Physici  | an                      | Decedent's Name (First, Middle, Last)  | 2. Date of De<br>Month                      | ath<br>Day                            | 3. Time of Death   |
|            | /Medic   | al                      | GERTRUDE SACHS HERSHEY  4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of De  | /2<br>eath                                  | 4c. County                            | 005 /2./5 p.M  |
|            | Examin   | er                      | Hebrew Home Rockville  |   |                                       | gomery   |
|            | Funeral  |                         | 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 H  | lin. 8. Date of Bir (Month, Da July 2       | th                                    | Birthplace (State or Foreign Country)                                  |
|            | Director   |                         | Usuel Residence of Decedent  | July 2                                      | 5 1920                                | Puerto Rico  |
|            | aryland<br>show  |                         | 10a. State 10b. County 10c. City, Town or Location   |   |                                       | 10d. Inside City Limits  |
|            | he Ma  | ecto                    | MD Montgomery Rockville  10e. Street and Number 10f. Zip Code  |   | 40- Citizen et M                      | 1 ☐ Yes 2 🖾 No   |
|            | 3a or  | <b>Funeral Director</b> | 10e. Street and Number 10f. Zip Code 6121 Montrose Road #481 20850   |   | 10g. Citizen of V<br>United S         |  |
|            | death  | nera                    | 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? Armed Forces? 13. Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pur   | (Specify Yes or No                          | - 14. Rac                             | e - American Indian,<br>ck, White, etc.                                |
| 36         | s after  | by Fu                   | 1 Never Married 2 Married 1 Yes 2 No If Yes, Give 1 Yes 2 No Specify: Year or Dates:   | 3000  |                                       | . White  |
| 21215-0036 | be filed within 72 hours after death with the Maryland tal Hyglene. Id other than "natural", or items 23a or 28a-1 show event, the Medicel Exactinat must be notified at | ted t                   | 15. Decedent's Education 16a. Decedent's Usual Occupation  |   | 16b. Kind of Bu                       | usiness/Industry   |
| 215        | - × 30   | Completed               | (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)  (Give kind of work done during most of well life. DO NOT use retired)   | working                                     |                                       |  |
| 121        | filed w<br>Hygier<br>Ither th  |                         | 4 Homemaker  17. Father's Name (First, Middle, Last)  18. Mother's N   | Name (First, Middle                         | Own Ho                                |  |
| lau        | should be filed withir<br>nd Mental Hyglene.<br>marked other than<br>imatic event, I'ce Mi   | To Be                   |  | le Harris                                   |                                       | <b>5</b> /   |
| Maryland   | shou<br>and M<br>is mar  | -                       | 19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or   |   |                                       |  |
|            | tealth<br>m 27<br>her tr   |                         | Anne Garner, Daughter 3424 Old Walnut Aven   | nue Owing                                   |                                       |  |
| Baltimore, | permit. Pages 1 and 2 should be<br>Department of Health and Menta<br>Important: If item 27 is marked<br>any injury or other traumatic or                                 |                         | 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State  |   |                                       | City or Town, State  |
| atiu       | partme<br>portan<br>injury   |                         | `4 □ Donation 5 □ Other (Specify) Mt. Lebanon Cemetery 12— 21. Signature of Funeral Service Liberasee 22. Name and Address of Facility   | -08-2005<br>Hines-Rin                       | Adelphi<br>aldi Fun                   | eral Home Inc  |
| Ö          | Per<br>Imp   |                         | 1800 New Hampshir  |   |                                       |  |
|            |  |                         | 23a. (Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as card shock, or reart failure. List only one cause on each line.  |   | rrest,                                | Approximate<br>Interval Between<br>Onset and Death                     |
|            | Pnysician<br>/Medical  |                         | Immediate Cause (Final disease or condition resulting in death)  a. CaRdio-Respiratory arrivating in death)  | rest  |                                       | Onset and Death  |
|            | Examiner   |                         | Immediate Cause (Final disease or condition resulting in death)  a. CaRdio-Respiratory ari Due to (or as a consequence of):  Sequentially list conditions,  b. CoRonary vascular dis   | cace  |                                       |  |
|            | p .∺   | ner                     | if any, leading to immediate Due to [or as a consequence of]:  |   |                                       |  |
|            | xecute<br>and<br>II-trans  | Examiner                | Cause (Disease or injury that initiated events c. Due to (or as a consequence of):   |   |                                       |  |
| 8760,      | cate be executed<br>physician and<br>the burial-transit  | cal E                   | d  |   |                                       |  |
| 9          | rtificat<br>ng phy<br>s as th  |                         | IF FEMALE:   |   |                                       |  |
| Вох        | death certifica<br>e attending ph<br>d for use as th   | lan/I                   | 23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy  |   | 23d. Dat                              | e of delivery<br>hth Day Year  |
| o.         | that the de<br>ed by the a<br>detached   | Physiclan/Med           | 1  Yes 2 No 4 Pregnant at time of death 5 Other (specify) 9 Unknown  |   |                                       |  |
| S, D       | 8 5 9  | by PI                   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   | 23e. Did t                                  | obacco use contr                      | ibute to the cause of death?   |
| ord        | w require<br>been sis  | sted                    | sepsis poor nutrition recto-vaginal  | _ 10'                                       | res 2□No                              | 3 Probably 4 Unknown   |
| Records,   | 0 - 0  | Completed               | fistulas dementia hypertension   | 24a. Was<br>autop                           | sy L p                                | Vere autopsy findings available prior to completion of cause of leath? |
| Vital      |  | 0                       | debression is of pneumonia 471 25. Was case referred to media.   | 1 ☐ Yes<br>Death (Check only o              | 2 No 1                                | ☐Yes 2☐No  |
| f Vi       | y S  | To B                    | examiner? Hospital: Other  | g Home 5 Resid                              |                                       | ar (Specify)   |
| n of       | ng<br>ffer<br>ine  |                         | 27. Manner of Death  1 ✓ Natural 5 ☐ Pending  28a. Date of Injury (Month, Day Year)  28b. Time of 28c. Injury at Injury Work?  | 28d. Describe I                             | now injury occurre                    | ed   |
| Division   | Attending<br>r death.<br>ector: After<br>by the funer  | licat                   | 2 Accident investigation M 1 Yes 2 No 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office  | 28f. Location (                             | Street and Number                     | er or Rural Route Number.  |
| ο̈́ς       | al or A<br>safter<br>Il Dire   | Certification:          | 4 Homicide determined building, etc. (Specify)   | City or Tov                                 |                                       | , or right rode realist,   |
|            | To the Hospital or Attendi<br>within 24 hours after death.<br>To the Funeral Director: A<br>completely filled in by the fu   | edical (                | 29a. Certifier (Check only one)  Certifying Physicien: To the best of my knowledge, death occurred at the time, date and pla 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and pla 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and pla 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and pla 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and pla 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and pla 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and pla 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and pla 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and pla 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion and occurred at the time, date and pla 2 Medical Examiner: On the basis of examination and/or investigation, and the control of the control | ace, and due to the<br>courred at the time, | cause(s) and mai<br>date and place, a | nner as stated.<br>ind due to the cause(s)                             |
|            | To the<br>within<br>To the<br>comple   | Me                      | 29b. Signature and title of certifier 29c. License number  |   |                                       | (Month, Day, Year)   |
| 1          | 2  |                         | My helle M. D D0055362   | 1   | 12-6-                                 |  |
|            |  |                         | 30. Name and address of person who completed cause of death (Itom 33a) (Type, Print) / RINA SE   | LE MO                                       | D Kais<br>2085                        | er her manent  |
|            | Sta<br>Registr   | - 6                     | 31. Date filed (Month, Day, Year)  DEC 0 9 2005  32. Registrar's Signature   |   |                                       |  |

|                            |  | -94%           | 1 - State<br>Registrar   | State o   | f Marylar  |                                  | artmer<br><i>rtificat</i>            |                             |  | nd Me                      | _                                   | giene<br>Reg. No.    | 005                              | 41600   |
|----------------------------|--|----------------|--|---|--|----------------------------------|--------------------------------------|-----------------------------|--|----------------------------|-------------------------------------|----------------------|----------------------------------|---|
| 2                          | Physici<br>/Medic  |                | 1. Decedent's Name (First, Middle, La  |   |  |                                  |                                      |                             |  |                            | Month                               | Day                  |                                  |   |
|                            | Examin   |                | 4a. Facility Name (If not institution, give MONTGOMERY GA  |   |  | TAL                              |                                      | Town, or                    | Location of                              |                            | A                                   |                      | County of De                     | ath<br>DMERY  |
| ·<br>数:                    | Funeral<br>Director  |                | 5/9-10-31/5  | ex<br>XIM 2□F   | 7. Age (In yrs.<br>82                                  | last birthday)<br>Yrs.           | If Unde<br>Months                    | Days                        | If Under 2                               | Min.                       | Date of Bir<br>(Month, Da<br>Feb. 2 | y, Year)             | 9. B<br>923 Wa                   | irthplace (State or Foreign<br>Country)<br>shington, DC |
|                            | death with the Maryland<br>ms 23a or 28a-f show<br>fritted by righted at   | ctor           | Usual Residence of Decedent  10a. State 10b. County  Maryland Montgo   | mery  |  | ty, Town or Lo                   |                                      | <b>3</b>                    |  |                            |                                     |                      |                                  | 10d. Inside City Limits 1 Yes 2 No                      |
|                            | 3a or 28   | i Director     | 10e. Street and Number 15310 Pine Orcha  | rd Driv   | e, #1B   |                                  | 10f. Zi <sub>i</sub>                 | Code 0906                   |  |                            |                                     | 10g. Citi            | zen of What (                    | Country?  |
| 5-0036                     | or its   | by Funeral     | 11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced   | 12. Was Dec<br>Armed Fo<br>1 TYPes<br>If Yes, Gi<br>Year or D | 2 No WW]   |                                  | Was Dece<br>If Yes, spe<br>1  Yes    | offy Cuba                   | ispanic Origi<br>n, Mexican,<br>Specify: | in? (Specr<br>Puerto Ri    | fy Yes or No<br>can, etc.)          | )-                   |                                  | nerican Indian,<br>nite, etc.                           |
| 0-61212                    | within 72 ho<br>ene.<br>then "natur<br>be Medical  | Completed      | 15. Decedent's E<br>(Specify only highest gra<br>Elementary/Secondary (0-12)   |   | 1-4or 5+)  | life.                            | dent's Usu<br>kind of wo<br>DO NOT u | ork done d<br>se retired    | during most (<br>)                       | of working                 | 7                                   | Dis                  | nd of Busines<br>trict<br>ernmen | of Columbia   |
| /land                      | uld be filed<br>Mental Hygi<br>irked other<br>itic event, I  | To Be C        | 17. Father's Name (First, Middle, Last<br>Stanley Herr   |   |  |                                  |                                      |                             | 18. Mother                               |                            | First, Middle                       |                      | Sumame)                          |   |
| Mar                        | jes 1 end 2 should b<br>of Health and Ments<br>if item 27 is marked<br>or other traumatic a  |                | 19a. Informant's Name/Relationship ( Ruth A. Herr/ Wif   | ., . ,  |  |                                  |                                      |                             |  |                            |                                     |                      | r Town, State,<br>lver S         | Zip Code) pring, MD 2090                                |
| Baitimore,                 | mit. Pages 1 er<br>partment of Hea<br>sortant: If item?<br>Injury or other   |                | 20a. Method of Disposition 1 ☐ Burial 2 ☐ €remation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special  |   | State  | Place of Dispo<br>cemetery, crei | sition (Na<br>matory or              | me of<br>other plac         | e) De                                    | Pat<br>ecembe<br>2005      | r 10                                | 20c. Lo              | cation - City o                  | or Town, State  |
| Balti                      | permit. Pag<br>Department<br>Important:<br>any injuty once.  |                | 21. Signature of Operal Service Licer  |   | ole  | ř                                | rane.                                | ed Addje                    | s Coly                                   | ins E                      | Funera                              | l Ho                 | me Inc                           | ng, MD 20901  |
|                            | Physician<br>/Medical  |                | 23a. Part1. Enter the disease, or com<br>shock, or heart failure. List only<br>Immediate Cause (Final<br>disease or condition<br>resulting in death) | a   | ach line.  | th. Do not ent                   | ter the mod                          |                             |  |                            |                                     |                      |                                  | Approximate Interval Between Onset and Death            |
| *                          | Examiner   | niner          | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury  | b   | NFEC<br>(or as a consec                                | TIDUS                            | C01                                  | LTI                         | <u> </u>                                 |                            |                                     |                      |                                  | 4WEEKS  |
| 8/60,                      | icate be executed physicien and s the burial-transit   | dical Examin   | that initiated events resulting in death) Last   |   | (or as a consecution NON -                             | quence of):                      | LEVA                                 | TOP                         | JMI                                      | OCAR                       | -DIAL                               | INF                  | ARCTO                            | 2 DAYS  |
| O. Box 6                   | ath certif<br>attending<br>for use a:  | Physician/Med  | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No   | 1 🗆 Live t  | tcome of pregn<br>pirth 2 Feta<br>nant at time of cown | aldeath 3[                       | ⊒Ectopic p<br>⊒ Other (s             |                             |  |                            |                                     |                      | 23d. Date of d<br>Month          | elivery<br>Day Year                                     |
| 1                          | vrequires that the de<br>been signed by the s<br>should be detached  | þ              | Part II, Other significant conditions  | contributing to d   | _  | sulting in the u                 | nderlying                            | cause give                  | en in Part I.                            |                            |                                     | tobacco u<br>Yes 2[  |                                  | to the cause of death?  Probably 4 MUnknown             |
| Division of Vital Hecords, | sician: The law re<br>certificate has bee<br>irector, page 2 sho   | Completed      | ACUT   | = REN   | ALF  | AILURI                           | E                                    |                             |  |                            | 24a. Was<br>auto<br>perfe<br>1 Yes  |                      | prior to<br>death?               | autopsy findings available ocompletion of cause of      |
| 1 VIII                     | ysician<br>us certifi<br>director  | To Be          | 25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No  | Hospital:   | npatient 2   | ] ER/Outpatier                   | nt 3 🗆 D                             | Othe Othe                   | 00                                       |                            | Check only                          |                      | 5 □Other (Sp                     | pecify)   |
| o uois                     | To the Hospitel or Attending Physician: within 24 hours after death.  To the Funerel Director: After this certifical completely filled in by the funeral director, |                | 27. Manner of Death  1. ► Natural 5 Pending 2 Accident Investigatio  | n   | of Injury<br>th, Day Year)                             | 28b. Time o<br>Injury            | f<br>M                               | 28c, Injun<br>Work<br>1 🔲 ' |  | 28                         | d. Describe                         |                      |                                  |   |
| DIX                        | itel or Att<br>urs after de<br>rel Direct  | Certification: | 3 Suicide 6 Could not be determined  | 289. Place<br>build   | of Injury - At h                                       | ify)                             |                                      |                             |  |                            | City or To                          | wn, State            | )                                | Rural Route Number,                                     |
|                            | ha Hosp<br>n 24 hou<br>ha Fune<br>pletely fii  | Medical        | 29a. Certifier 1 S. Certifying Pl<br>(Check only 2 Medical Exel  | niner: On the b   | best of my kn<br>asis of examina<br>ner stated.        | owledge, deat<br>ation and/or in | h occurred<br>vestigation            | at the time<br>n, in my of  | ne, date and<br>pinion, death            | l place, and<br>n occurred | d due to the<br>I at the time,      | cause(s)<br>date and | and manner and du                | as stated.<br>ue to the cause(s)                        |
|                            | Within Comp  | Σ              | 29b. Signature and title of certifier  | AH  | KPITAI   | 16.                              |                                      | c. License                  |  | 7                          | ,                                   |                      | _                                | nth, Day, Year)   |
|                            | To.  |                | 30. Name and address of person who SONIA HOLMES  | completed cau   | se of death (Ite                                       | m 23a) (Type,                    | Print)                               | UIP                         | DRIV                                     | E, OL                      | NEY                                 | MAI                  | ZYLAN                            | D 20832   |
|                            | Sta<br>Regist  |                | 31. Date filed (Month, Day, Year) DEC 0 9 2  | 005 32.F  | legistrar's Sign                                       | ature                            | action .                             |                             |  |                            |                                     |                      |                                  |   |

AEM 05-08257

Jason David Hurd

Unpend item 23a, 111, 27, perm 3850, 12/29/05, Tr

State of Maryland / Department of Health and Mental Hygiene 1 15 1 - For Stata Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death December 7, 2005 **Physician** Jason David Hurd 11:10 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Worcester Ocean City 12614 Ocean Gateway 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7-22-1974 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** 1**X**□ M 2□ F 217-80-7630 Director MĎ Usual Residence of Decedent with the Maryland 10b. County 10a State 10c. City, Town or Location 10d. Inside City Limits rthan "natural", or Itams 23a or 28a-f ahow Ita Medical Examinar must be notified at MD Worcester Berlin Director X☐Yes 2☐No 10e. Street and Number 10f. Zio Code 10g. Citizen of What Country? 674 Ocean Parkway Funeral 21811 US 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Yes 2X No If Yes, Give Year or Dates: 1X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 Specify.White 1 ☐ Yes 2 No Š 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Singer Orchestra 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Depertment of Health and Mental Hy Important: if Item 27 is marked oth any liqury or other traumatic avent once. David Clark Hurd Melanie Carol Eva King 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Melanie Carol Rhodes 674 Ocean Parkway, Berlin, Md. 21811 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 12-12-2005 Frankford, DE 4 ☐ Donation 5 ☐ Other (Specify) Cape Henlopen Crem. 21. Sign yor Juner Fervice Licensee 22. Name and Address of Facility The Burbage Funeral Home 108 William St., Berlin, Md. 21811 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failule. List only one cause or each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician Dilated cardiomyopathy /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine or Attending Physician: The law requires that the death certificate be executed ettending physicien and for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 2 | Fetal death in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4☐Pregnant at time of death 5 Other (specify) ed by the detached 9 Unknown 9 Unknown signed l Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š Chronic alcohol abuse Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4X ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No has page 2 autopsy performed? Yes 2 □ No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Scene ္ရ 1. Yes 2 No 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 28b. Time of 28d. Describe how injury occurred After 1X Natural Injury 5 Pending М 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: 6 Could not be determined 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifies 29c. License number 29d. Date signed (Month, Day, Year) OCME December 8, 2005 Name address of person who completed cause of death (Item 23a) (Type, Print) SUCAND 111 Penn Street, Baltimore Maryland 21201 No 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

State

Registrar

DEC 12

2005

32. Registrar's Signature

CPM 05-08329 Eliezer l

Please Type or Print in Black Indelible Ink Ensure All Copies Are Logible

| iez                        | er Rodi  | rig            | UCZ  For State Registrar  |                               | State of                             | f Maryla                 | nd / Dep                |   | t of H                    | ealth a                  | and N                    | lental Hy                             |                            | ~                                     | 5                     | 41602  |
|----------------------------|--|----------------|---|-------------------------------|--------------------------------------|--------------------------|-------------------------|---|---------------------------|--------------------------|--------------------------|---------------------------------------|----------------------------|---------------------------------------|-----------------------|--|
|                            |  |                | Decedent's Name (Firs   | t, Middle, Las                | t)                                   |                          |                         |   |                           |                          |                          | 2. Date of De                         |                            |                                       |                       | 3. Time of Death                                   |
|                            | Physic<br>/Medi  |                | Eliezer R   | odrigu                        | ez Hern                              | andez                    |                         |   |                           |                          |                          | Decemb                                | er 10                      | ) 3                                   | 005                   | 03:27 A <sup>M</sup>                               |
|                            | Exami  |                | 4a. Facility Name (If not in  |                               |                                      |                          |                         | 4b. City,                               | Town, or                  | Location                 | of Death                 | Decamp                                |                            | County of                             |                       | 05.27 A  |
|                            |  |                | Washington  | Count                         | y Hospi                              | tal                      |                         |   |                           | stow                     |                          |                                       |                            | ashir                                 |                       | า  |
|                            | Funeral  |                | 5. Social Security Number   | 6. Se                         | ex                                   |                          | s. last birthday,       | If Under                                | 1 Year                    | If Under                 | 24 Hrs.                  | 8. Date of Bir<br>(Month, Da          |                            |                                       |                       | lace (State or Foreign try)                        |
|                            | Director   |                | 583-93-9383   | 12                            | <b>©</b> M 2□F                       |                          | 22 Yrs.                 | Months                                  | Days                      | Hours                    | Min.                     | July 10                               | iy, Year)<br>5 <b>1</b> 98 |                                       |                       | to Rico  |
| •                          | P  |                | Usual Residence of Dece   |                               |                                      |                          |                         |   |                           |                          |                          | outy i                                | 0 120                      |                                       | T LICI                | TO_RICO  |
|                            | the Marylan<br>r 28a-f ehow<br>rotified at   | _              |   | County                        |                                      | 10c. 0                   | City, Town or L         |   |                           |                          |                          |                                       |                            |                                       | 10                    | Od. Inside City Limits                             |
|                            | M er F   | octo           | Maryland  | Washir                        | igton                                |                          | Hager                   | stown                                   |                           |                          |                          |                                       |                            |                                       |                       | 1 X Yes 2 □ No                                     |
|                            | death with the Maryland<br>me 23a or 28a-f ehow<br>misst be notified at  | Director       | 10e. Street and Number  |                               | C4                                   |                          |                         | 10f. Zip                                |                           |                          |                          |                                       | 10g. Citiz                 | zen of Wh                             | at Coun               | try?   |
|                            | ath v  | by Funerai     | 600 N. Pro  | spect                         |                                      |                          |                         |   |                           | 740                      |                          |                                       |                            | J.S.A                                 | •                     |  |
|                            |  | une            | 11. Marital Status  |                               | 12. Was Dece<br>Armed For            | rces?                    | U.S. 13.                | Was Deced                               | dent of His<br>ofly Cubar | spanic Ori<br>n, Mexicar | igin? (Spi<br>n, Puerto  | ecify Yes or No<br>Rican, etc.)       | - 1                        | <ol> <li>Race -<br/>Black.</li> </ol> | America<br>White, e   | an Indian,   |
| 36                         | hours after<br>ture!, or its   | Ϋ́             | Wildowed 4 □ D  |                               | 1 ☐ Yes<br>If Yes, Giv<br>Year or Da | 9                        |                         | 1 Yes                                   | 2□ No                     | Specify:                 | :                        |                                       |                            | Specify:                              | Hisp                  | anic   |
| Maryland 21215-0036        | hou  | edi            |   | ecedent's Ed                  |                                      | 105:                     | 163 Dogg                | dost's Have                             | I Ossuss                  | tion                     |                          |                                       |                            |                                       |                       |  |
| 15                         | in 72<br>n nat   | Completed      | (Specify onl  | y highest gra                 | de completed)                        |                          | (Give                   | dent's Usua<br>kind of woi<br>DO NOT us | rk done di<br>se retiredì | uring mos                | st of work               | ing                                   | 16b. Kir                   | nd of Busi                            | ness/ind              | lustry   |
| 12                         | d withing the state of the stat | E              | Elementary/Secondary 9  | (0-12)                        | College (1                           | -4or 5+)                 |                         | unemp.                                  |                           |                          |                          |                                       |                            |                                       |                       |  |
| D                          | E T & E  | O              | 17. Father's Name (First,   | Middle, Last)                 |                                      |                          |                         |   |                           |                          | er's Name                | (First, Middle,                       | Maiden :                   | Sumame)                               |                       |  |
| <u>a</u>                   | \$ 5 5 5   | 0 0            | Eli Samuel  | Rodri                         | guez                                 |                          |                         |   |                           |                          |                          | Hernand                               |                            |                                       |                       |  |
| 2                          | 2 should I<br>and Meni<br>is marked  | -              | 19a. Informant's Name/R   | elationship (7                | ype, Print)                          |                          | 19b. Maili              | na Address                              | (Street a                 |                          | -                        | A Route Number                        |                            | Tour St                               | ato Zio               | Code   |
| Σ                          | s 1 and 2 should<br>I Health and Mer<br>Item 27 Is marks<br>other treumatic  |                | Ivette Her  |                               |                                      | r)                       |                         |   |                           |                          |                          |                                       |                            |                                       |                       | nd 21740   |
| <u>ව</u>                   | of Heal  |                | 20a. Method of Disposition  |                               |                                      | <u> </u>                 | Place of Dispo          | osition (Nan                            | ne of                     |                          | CLCC                     | ate                                   | 20c. Loc                   | cation - Ci                           | ty or Toy             | na Z1/40   |
| Baltimore,                 | 80= 5  | 1              | 1 🔀 Burial 2 □ Crer<br>4 □ Donation 5 □ C   | nation 3                      | Removal from S                       |                          | cemetery.cre<br>Se Hill |   |                           | - 1                      | 10 1                     | - 0-                                  |                            |                                       |                       |  |
|                            | permit. Pag<br>Depertment<br>Importent:<br>eny injury o  |                | 21. Signature of Funeral S  |                               |                                      | 110                      |                         | 2. Name an                              |                           |                          | 12–1                     |                                       |                            |                                       |                       | Maryland   |
| ä                          | permit. Depertuimportui |                | 1   | 10 1                          | × 7/1                                | ,                        |                         |   |                           |                          |                          | uglas A                               | . Fie                      | ery E                                 | une                   | ral Home   |
|                            |  |                | 3a. Part1. Enter the dise   | ase or comp                   | lications that ca                    | gused the dea            | ath. Do not en          | I 331 E                                 | aste                      | rn B                     | Ivd.                     | N. Hag                                | erst                       | own M                                 | lary                  | land 21742   |
|                            |  |                | shock, or he in failu<br>Immediate Cause (Final   | e. List only                  | NIG THUSE OF BE                      | ach ime.                 |                         |   |                           |                          |                          | i respiratory ar                      | 1951,                      |                                       |                       | Approximate<br>Interval Between<br>Onset and Death |
|                            | Physician<br>/Medical  |                | disease or condition resulting in death)  | _                             | a                                    | ab wo                    | undsl                   | 2) t                                    | 6 +                       | 0170                     |                          |                                       |                            |                                       |                       | onsor and boatty                                   |
| 1                          | Examiner   |                | W. O.   |                               | Due to (                             | or as a conse            | quence of):             |   |                           |                          |                          |                                       |                            |                                       |                       |  |
|                            |  | 5              | Sequentially list condition   | s,                            | b. — Della Ro Cr                     | of as a conse            | danger of the           |   |                           |                          |                          |                                       |                            |                                       |                       |  |
|                            | ted  | n l            | Sequentially list condition<br>cause. Enter Underlying<br>Cause (Disease or injury<br>that initiated events | " <b>~</b>                    | 2001010                              | or as a consc            | quante on,              |   |                           |                          |                          |                                       |                            |                                       |                       |  |
|                            | ste be executed<br>sysician and<br>he burial-transit   | Examiner       | that initiated events resulting in death) Last  |                               | c. Due to (c                         | or as a conse            | guence of):             |   |                           |                          | _                        |                                       |                            |                                       | 4                     |  |
| 8760,                      | be e<br>ician<br>buriè   | Cai            |   |                               | ,                                    |                          | 4-511-5-517.            |   |                           |                          |                          |                                       |                            |                                       | 1                     |  |
| 387                        |  | g              |   |                               | d                                    |                          |                         | <del></del> -                           |                           |                          |                          |                                       |                            |                                       |                       |  |
| Box 6                      | eath certific<br>ettending p<br>I for use as I   | Physician/Med  | IF FEMALE:  |                               | 23c. If yes, outo                    | come of prear            | nancy                   |   |                           |                          |                          |                                       |                            |                                       | -                     |  |
| B                          | death<br>e etten<br>ed for u   | cian           | 23b. Was decedent pregr<br>in the past 12 month   | CHIT                          | 1 ☐ Live bi                          | rth 2 ☐ Fet              | tal death 3[            | Ectopic pre                             |                           |                          |                          |                                       | 23                         | 3d. Date of Month                     |                       | y<br>Day Year                                      |
| P.O.                       | 0 0  | ysi            | 1 ∐ Yes 2 ∏ No<br>9 ∐ Unknown   |                               | 9☐ Unkno                             |                          | deall J                 | Other (spe                              | 9City)                    |                          |                          |                                       |                            |                                       |                       | ,  |
|                            | equires that the de<br>sen signed by the e<br>rould be detached t  | 4              | Part II. Other significant of   | onditions co                  | ntributing to de                     | ath but not re           | sulting in the u        | nderiving ca                            | use giver                 | n in Part I              |                          | 23a Did to                            | phacen us                  | e contribu                            | ite to the            | cause of death?                                    |
| ds                         | uires<br>sign<br>d be  | d by           |   |                               |                                      |                          | •                       | ,                                       | <b>3</b>                  |                          | •                        |                                       | es 20                      |                                       |                       | bly 4 Unknown                                      |
| Division of Vital Records, | 2 0 5  | Completed      |   |                               |                                      |                          |                         |   |                           |                          |                          | -                                     |                            |                                       |                       |  |
| ě                          | sicien: The law<br>s certificate has l<br>lirector, page 2 s   | ם              |   |                               |                                      |                          |                         |   |                           |                          |                          | 24a. Was<br>autop                     | sy !                       | Drio                                  | r to com              | sy findings available pletion of cause of          |
| <u></u>                    | r: Tr  |                |   |                               |                                      |                          |                         |   |                           |                          |                          | 1 Yes                                 | med?<br>2 ☐ No             | dea<br>1 D                            | Yes 2                 | 2 □ No   |
| ξ                          | Attending Physicien: r death. sctor: After this certifici<br>by the funeral director,  | Be             | 25. Was case referred to examiner?  | -                             | العدر: Hospital:                     |                          |                         |   | - I -                     |                          | of Death                 | (Check only of                        | ne)                        |                                       |                       |  |
| of                         | Phys<br>this<br>ral di   | 2              | 1X Yes 2 No<br>27. Manner of Death  |                               | 1 LAIn                               |                          | ER/Outpatier            |   |                           | 4 🗆 140                  |                          | ne 5 🗆 Resid                          |                            |                                       | (Specify)             |  |
| L C                        | ding<br>After<br>fune  | Certification: | t Natural 5   | Pending                       |                                      | f Injury<br>n, Day Year) | 28b. Time of<br>Injury  |   | Bc. Injury a<br>Work?     |                          | 1                        | 28d. Describe h                       | ow injury                  | occurred                              | ctr. 1                | bbod   |
| 2                          | death<br>death<br>ctor:  | Ca             | 2 Accident 3 Suicide 6  | investigation<br>Could not be | 12-10                                |                          |                         | AM                                      |                           | es 2 1                   |                          | July .e                               |                            |                                       |                       |  |
| .≥                         | efter<br>Otre  | ŧ              | 4 Homicide  | determined                    | buildin                              | g, etc. (Spec            |                         | 1                                       | office                    |                          | 2                        | 28f. Location (S<br>City or Tow       | itreet and<br>m. State)    | Number o                              | or Rural              | Route Number,                                      |
| _                          | pital<br>ours<br>erei<br>filled  |                | 29a. Certifier 1 ☐ C  | ertifying Phy                 | reinion. To the                      | hoot of my ke            | Stre                    |   |                           |                          | 1                        | IVE: TIC                              | 186 82.                    | ton                                   | mo                    | ,  |
|                            | To the Hospital or Attending Physicien: within 24 hours effer death. To the Funeral Director: Affer this certific completely filled in by the funeral director.  | Medical        | (Check only one)  | edical Exam                   | sicien: To the iner: On the ba       | sis of examin            | ation and/or in         | n occurred a<br>vestigation,            | at the time<br>in my opi  | nion, deal               | d place, a<br>th occurre | and due to the o<br>ad at the time, o | ause(s) a<br>date and p    | ind manne<br>place, and               | er as sta<br>due to t | ted.<br>the cause(s)                               |
|                            | ithin<br>of the  | Me             | 29b. Signature and title of   |                               | and marrin                           | 51 Stateu.               |                         |   | License                   |                          |                          |                                       |                            |                                       |                       |  |
|                            | ⊢≯⊢ŏ   |                |   | ن ، ا                         | C. A                                 |                          |                         | 200.                                    |                           |                          | 1                        |                                       |                            | signed (A                             |                       |  |
|                            |  |                |   |                               |                                      |                          |                         |   | 0.0                       | C.M.E                    | •                        |                                       | pecei                      | nper                                  | 11,                   | 2005   |
| 14                         | 4-0  |                | 30. Name and address of   |                               |                                      | of death (Ite            |                         |   | Stre                      | et                       | Ral+                     | imore,                                | Marre                      | land                                  | 2124                  | <b>1</b>   |
|                            | Sta  | te             | 31. Date filed (Month, Day  |                               |                                      | gistrar's Sign           |                         | - 01111                                 | DULC                      | ,                        | LUIL.                    | riiore,                               | LICIL Y.                   | U                                     | 414                   | ) T  |
|                            | Registr  |                |   | 1 4 20                        | 100                                  | -                        | U. So                   | and s                                   |                           |                          |                          |                                       |                            |                                       |                       |  |
| DHI                        | MH 17 Rev 1/2  |                | W La V  |                               | - Julie                              | 15 July 1                | A. 12/2                 |   |                           |                          |                          |                                       |                            |                                       |                       |  |

|            |  |                 | 1 - For<br>State<br>Registrar   | State of Ma                                     | ryland / Depa<br><i>Cei</i>           | artment of                           | Health and                           |  | ieme 0 0 5                            | 41603                                    |
|------------|--|-----------------|---|---|---------------------------------------|--------------------------------------|--------------------------------------|--|---------------------------------------|--|
| <b>产</b>   | - 8  | -               | Decedent's Name (First, Middle, Last)   |   |                                       |                                      |                                      | 2. Date of Deat                          | th                                    | 3. Time of Death                         |
|            | Physici<br>/Medic  |                 | WILLIAM ELVIN HURS  | ST  |                                       |                                      |                                      | DECEMBE:                                 | R 7 200                               | 5 2:00P M                                |
| 1          | Examin   |                 | 4a. Facility Name (If not institution, give stre  | eet and number)                                 |                                       | 4b. City, Town,                      | or Location of De                    | eath                                     | 4c. County of De                      | eath                                     |
|            |  | Merican Company | FREDERICK MEMORIAI  |   |                                       | FREDERI                              |                                      |  | FREDERI                               | CK                                       |
|            | Funeral  |                 | 5. Social Security Number 6. Sex 123-28-1373  | 7. Age  | (In yrs. last birthday)<br>74 Yrs.    | If Under 1 Yea<br>Months Day         |                                      | in. (Month, Day,                         | Year)                                 | Birthplace (State or Foreign<br>Country) |
| .E.        | Director   |                 | Usual Residence of Decedent   |   | 74 113.                               |                                      |                                      | APRIL 1                                  | 4 1931 Ba                             | altimore, MD                             |
|            | yland<br>pow   |                 | 10a. State 10b. County  |   | 10c. City, Town or Lo                 | cation                               |                                      |  |                                       | 10d. Inside City Limits                  |
|            | Mar  | tor             | MD Frederic   | k   | Brunswi                               | .ck                                  |                                      |  |                                       | 12⊠Wes 2 □ No                            |
|            | th the   | Director        | 10e. Street and Number  | ,   |                                       | 10f. Zip Code                        |                                      | 1  | 0g. Citizen of What                   | Country?                                 |
|            | 23a (23a)  | le              | 8 S. Virginia Avenu   | e   |                                       | 2171                                 | 6                                    |  | USA                                   |  |
|            | teme<br>teme   | Funeral         |   | Was Decedent E<br>Armed Forces?                 |                                       | Was Decedent of<br>f Yes, specify Cu | Hispanic Origin?<br>ban, Mexican, Pu | (Specify Yes or No-<br>erto Rican, etc.) | 14. Race - Ar<br>Black, W             | merican Indian,<br>hite, etc.            |
| 9          | s afte   | by F            | 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced  | 1 ☐ Yes 2 ☑ N<br>If Yes, Give<br>Year or Dates: |                                       | 1 ☐ Yes 2 🙀 No                       | Specify:                             |  | Specify:                              | White                                    |
| 몽          | tural  | edi             | 15. Decedent's Educat   |   | 16a Decer                             | dent's Usual Occi                    | unation                              |  | 16b. Kind of Busine                   | re/lodustry                              |
| 5          | nin 72<br>n "ne<br>Medik   | Completed       | (Specify only highest grade c   | ompleted)                                       | (Give                                 | kind of work don<br>DO NOT use retir | e during most of v                   | vorking                                  | TOO. KING OF BUSINES                  | ssilioustry                              |
| 7          | d with   | mo;             | 12  | College (1-4or 5-                               |                                       | ountant                              |                                      |  | Accountir                             | ng Service                               |
| 2          | 2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or Iteme 23a or 28a-f show aumatic event, the Madical Examiner must be notified at   | e               | 17. Father's Name (First, Middle, Last)   |   |                                       |                                      |                                      | lame (First, Middle, A                   | ,                                     |  |
| <u> </u>   | should b<br>and Menta<br>marked<br>umatice   | <u>ا</u>        | Charles Elvin Hurst   |   |                                       |                                      | Josep                                | hine Franc                               | es Bowen                              |  |
| =          | 2 sho  | 77              | 19a. Informant's Name/Relationship (Type,   | •   |                                       |                                      |                                      | Rural Route Number,                      |                                       |  |
|            | and<br>lealth<br>m 27  |                 | Lance K. Hurst, Son   |   |                                       |                                      |                                      | , Brunswic                               |                                       |  |
| Baltimore, | Pages 1 and 2 should be nent of Health and Ments nit. If Item 27 is marked ity or other traumatic e  |                 | 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Rerr  | noval from State                                | 20b. Place of Dispo<br>cemetery, cren |                                      |                                      |  | 20c. Location - City                  |  |
|            | permit. Page<br>Depertment i<br>Importent: If<br>any Injury o  | . 1             | 4 Donation 5 Other (Specify)  |   | Hagersto                              |                                      |                                      | /9/05 E                                  | lagerstown                            | ı, MD                                    |
| g          | Depermine Deperm |                 | 21. Signatura of Fundral Service Licenses   | ams, own  | ans I                                 | Name and Add                         | Williams                             | Funeral H                                | Iome                                  |  |
| 2          |  |                 | 23a. Part 1. Enter the disease, or complicate   |   |                                       |                                      |                                      | Road, Brun                               |                                       | 21716<br>Approximate                     |
| 1          |  |                 | shock, or heart failure. List only one of<br>Immediate Cause (Final   | cause on each line                              | ə.                                    |                                      |                                      |  | _1                                    | Interval Between<br>Onset and Death      |
| 1          | Physician<br>/Medical  |                 | disease or condition resulting in death)  | Die to lorge a                                  | consequence of);                      | aribi                                | everena                              | 1 acced                                  | m                                     | + days                                   |
| 355        | Examiner   |                 |   | 000 10 (01 23 2                                 | consequence or,                       |                                      |                                      |  |                                       | 0  |
|            | . •  | ner             | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | Due to (or as a                                 | consequence of):                      |                                      |                                      |  |                                       |  |
|            | ecuter<br>and<br>transi  | Examiner        | Cause (Disease or injury that initiated events c resulting in death) Last                                   |   |                                       |                                      |                                      |  |                                       |  |
| Ď,         | cien s   |                 | resulting in death, cast  | Due to (or as a                                 | consequence of):                      |                                      |                                      |  |                                       |  |
| 09/8       | the death certificate be executed<br>y the attending physicien and<br>iched for use as the burral-transit  | dlcal           | d   |   |                                       |                                      |                                      |  |                                       |  |
| S<br>X     | leath certific<br>attending p  | Physician/Me    | IF FEMALE: 23c.   | If yes, outcome o                               | of pregnancy                          |                                      |                                      |  | 201011                                |  |
| XOP .      | atter<br>for u   | clar            | in the past 12 months?  | 1 Live birth 2<br>4 Pregnant at t               | Fetal death 3                         | Ectopic pregnant<br>Other (specify)  | су                                   |  | 23d. Date of d<br>Month               | Day Year                                 |
| o .        | at the de<br>by the a<br>tached  | hysl            | 1 □ Yes 2 No<br>9 □ Unknown   | 9□ Unknown                                      |                                       |                                      |                                      |  |                                       |  |
| ,<br>J     | requires that<br>been signed b<br>hould be deta  | by P            | Part II. Other significant conditions contrib   | outing to death but                             | t not resulting in the ur             | nderlying cause g                    | ven in Part I.                       | 23e. Did tob                             | acco use contribute                   | to the cause of death?                   |
| ecords,    | quire<br>an sig  | ed t            |   |   |                                       |                                      |                                      | 1 □ Ye                                   | s 2 No 3                              | Probably 4 Unknown                       |
| ပ္ပ        | 2 S L  | Completed       |   |   |                                       |                                      |                                      | 24a. Was ar                              |                                       | autopsy findings available               |
| r,         | 0 4 0  | E O             |   |   |                                       |                                      |                                      | autopsy perform                          | prior to<br>death'<br>No 1 □ Ye       |  |
| VItal      | sicien: Th<br>certificete<br>rector, pag   | Bec             | 25. Was case referred to medical examiner?  |   |                                       |                                      | 26. Place of D                       | eath (Check only one                     |                                       |  |
| 5          | Physicien:<br>r this certific<br>ral director,   | 2               | 1 ☐ Yes 2 No  | pital: 1 Inpatien                               |                                       | t 3 DOA                              | ther: 4 🗆 Nursing                    | Home 5 ☐ Reside                          | nce 6 Other (Sp                       | pecity)                                  |
| ב<br>ב     | ding P<br>h.<br>After t<br>funera  | on:             | 27. Manner of Death  1 Natural 5 ☐ Pending  | 28a. Date of Injury<br>(Month, Day              | Year) 28b. Time of Injury             | 28c. Inju                            | ury at<br>ork?                       | 28d. Describe ho                         | w injury occurred                     |  |
| <u>s</u>   | tend<br>death<br>tor: /  | cat             | 2 Accident investigation 3 Suicide 6 Could not be   | 00 - Di 41-                                     |                                       |                                      | Yes 2 No                             |  |                                       |  |
| DIVISION   | or At<br>after of<br>Direction by  | Certification:  | 4 Homicide determined   | building, etc.                                  | y - At home, farm, stre<br>(Specify)  | eet, factory, office                 | )                                    | 28f. Location (Str<br>City or Town,      | eet and Number or i<br>, State)       | Rural Route Number,                      |
| -          | spital   |                 | 29a. Certifier 1X Certifying Physici  | an: To the best of                              | my knowledge death                    | occurred at the                      | ime date and nia                     | co. and due to the co.                   | uso(s) and manner                     | no otated                                |
| :          | To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer   | edical          | (Check only 2 Medical Exeminer one)   | On the basis of e                               | examination and/or inv                | estigation, in my                    | opinion, death oc                    | curred at the time, da                   | te and place, and di                  | ue to the cause(s)                       |
| :          | To th<br>Withir<br>To th<br>comp   | Me              | 29b. Signature and title of certifier   | 1   | Ι. Λ                                  | 29c. Licen                           | se number                            |  | d. Date signed (Moi                   |  |
|            | 0  |                 | ) (a). W  | Paier   | M.D                                   |                                      | 01607                                | 5  | DEC. 8,                               | , 2.005                                  |
|            | 3  |                 | 30. Name and address of person who comp   | leted cause of dea                              | ath (Item 23a) (Type, I               | Print)                               |                                      |  | \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ | _  |
|            |  |                 | W. Au   | other   | M.O.,                                 | 12 KAD                               | SWICK                                | , MD ?                                   | 1116                                  |  |
|            | Sta<br>Registr   |                 | 31. Date filed (Month, DEC' 1 2 2   | 005 Registar                                    | 's Signature                          | breeke                               |                                      |  |                                       |  |

|                     |  |                  | For State Registrar  | State of Ma                                    |                           | d / Depa                         |                                | of H                    | ealth a                     |                          |   | iene                    | 05   | 41604                             |  |
|---------------------|--|------------------|--|--|---------------------------|----------------------------------|--------------------------------|-------------------------|-----------------------------|--------------------------|---|-------------------------|--|-----------------------------------|--|
|                     |  |                  | Hegistrar     Decedent's Name (First, Middle, Las  | 1)   |                           |                                  | uncate                         | OIL                     | Jeani                       | 1                        | 2. Date of Dea  | eg. No.                 |  | 3. Time of Death                  |  |
|                     | Physici  | an               | WALTER CLINTON   |  |                           |                                  |                                |                         |                             |                          | Month   | Day                     | Year   |                                   |  |
|                     | /Medic   |                  | 4a. Facility Name (If not institution, give  |  |                           |                                  | 4h City T                      | lown or                 | Location of                 |                          | Decembe   |                         | 2005<br>ounty of Death                             | 8:15 A M                          |  |
|                     | Examir   | er.              | Bedford Court Se   | -  | nσ                        |                                  |                                |                         | Spri                        |                          |   |                         | Montgor  |                                   |  |
|                     | Funeral  |                  | 5. Social Security Number 6. Se  |  |                           | last birthday)                   | If Under 1                     | 1 Year                  | If Under 2                  | 24 Hrs.                  | 8. Date of Birth  |                         |  | place (State or Foreign<br>intry) |  |
| н                   | Director   |                  | 577.24.6159  | <b>X</b> M 2□F                                 | 91                        | Yrs.                             | Months                         | Days                    | Hours                       | Min.                     | (Month, Day   | Year)                   | 14 Wast  | nington, DC                       |  |
|                     | <b>p</b> .   |                  | Usual Residence of Decedent  |  |                           |                                  |                                |                         |                             |                          | bept: 2   | . 4 1/                  |  |                                   |  |
|                     | arylar   | _                | 10a. State 10b. County   |  |                           | y, Town or Lo                    | cation                         |                         |                             |                          |   |                         |  | 10d. Inside City Limits           |  |
|                     | Ba-f.  | cto              | Maryland Howard  |  | La                        | urel                             | ,                              |                         |                             |                          |   |                         |  | 1 X Yes 2 □ No                    |  |
|                     | ith th   | Funeral Director | 10e. Street and Number   |  |                           |                                  | 10f. Zip (                     |                         |                             |                          | 1   | 0g. Citize              | on of What Cou                                     | intry?                            |  |
|                     | ath v  | -E               | 8404 Sweet Cherr   |  |                           |                                  |                                | 723                     |                             |                          |   |                         | 5.A.   |                                   |  |
|                     | er de<br>Item  | nue              | 11. Marital Status   | 12. Was Decedent<br>Armed Forces?              |                           | .S. 13.                          | Was Decede<br>If Yes, specif   | ent of His<br>ify Cubar | spanic Orig<br>n, Mexican,  | gin? (Spe<br>, Puerto F  | cify Yes or No-<br>Rican, etc.)                         | 14                      | <ul> <li>Race - Amer<br/>Black, White</li> </ul>   |                                   |  |
| 36                  | rs aft   | by F             | 1 Never Married 2 Married  3 X Widowed 4 Divorced  | 1 XYes 2 □ I<br>If Yes, Give<br>Year or Dates: | WW :                      | 1 Ves OF No. Comits              |                                |                         |                             |                          | Specify: W  |                         |  | Mite                              |  |
| 9                   | ba filed within 72 hours after death with the Maryland ital Hygiene. id other than "natural", or items 23a or 28a-f show event, Ira Medical Examinational be mailised at | ed               | 15. Decedent's Ed  | ucation  |                           | 16a. Dece                        | dent's Usual                   | Occupa                  | ution                       |                          | 16b. Kind of Business                                   |                         |  | ndustry                           |  |
| 715                 | en 77  | plet             | (Specify only highest grade Elementary/Secondary (0-12)  | de completed) College (1-4or 5                 | :.\                       | (Give                            | kind of work<br>DO NOT use     | k done d                | luring most                 |                          | ng  |                         |  |                                   |  |
| 2                   | d withir<br>giene.<br>or than  | Completed        | 12th   | College (1-40)                                 | 7+)                       | Manag                            | ger &                          | Info                    | ormat                       | Spec:<br>ion             | ialist  | U.S.                    | Gover  | nment                             |  |
| 9                   | a filed<br>al Hygid<br>other<br>vent,  | Be C             | 17. Father's Name (First, Middle, Last)  |  |                           |                                  |                                |                         | 18. Mother                  | r's Name                 | (First, Middle,   | Waiden S                | umame)   |                                   |  |
| /ai                 | should ba<br>nd Mental<br>markad o   | 5                | Percy Clinton  | Jones  |                           |                                  |                                |                         | Caro                        | line                     | Α.  | Ander                   | cson   |                                   |  |
| Maryland 21215-0036 | 2 sho<br>and<br>is ma  |                  | 19a. Informant's Name/Relationship (7  | ype, Print)                                    |                           | 19b. Mailir                      | ng Address (                   | (Street a               | ind Numbe                   | r or Rura                | i Route Number  | City or T               | Town, State, Zi                                    | ip Code)                          |  |
|                     | Pages 1 and 2 should b<br>ment of Health and Ments<br>ant: if itam 27 is markad<br>ury or other traumatic e  |                  | Walter C. Jones, I   | I/Son  | 1                         | 8404                             | Sweet                          | Che                     | erry l                      | Lane                     | Laure   |                         |  |                                   |  |
| ore                 | ges 1<br>if ital   |                  | 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐  | Removal from State                             |                           | Place of Dispo<br>cometery, crea |                                |                         |                             |                          |   |                         | ation - City or T                                  |                                   |  |
| Ħ<br>H              | tmen<br>tant:  |                  | ` 4 □ Donation 5 □ Other (Specify  |  | Gat                       | e of I                           | leaven                         | Cen                     | ne.  12                     | 2/08,                    | /2005   | Silve                   | er Spri  | ng, MD                            |  |
| Baltimore,          | permit. Page<br>Department of<br>Important: If<br>any injury or<br>2005.   |                  | 21. Signature of Funeral Service Licen.  | -  | +                         | H                                | INES-I                         | Addres<br>RINA          | s of Facility               | UNER                     | AL HOME   | , IN                    | С.   | ng,MD 20904                       |  |
|                     |  |                  | 220 Part Cotor the disease of some   | Teres  | س ا                       | 1                                | 1800 1                         | New                     | Hamps                       | hire                     | Ave, S  | ilve                    | r Sprin  | ng,MD 20904                       |  |
|                     |  |                  | shock, or head affure. List only one cause on each line.  Interval B Onset a   |  |                           |                                  |                                |                         |                             |                          |   |                         | Approximate<br>Interval Between<br>Onset and Death |                                   |  |
|                     | Pnysician<br>/Medical  |                  | disease or condition resulting in death)   | a Acute My                                     |                           |                                  | nfarct                         | tion                    |                             |                          |   |                         |  | 1 Day                             |  |
|                     | Examiner   |                  | Due to (or as a consequence of):   |  |                           |                                  |                                |                         |                             |                          |   |                         |  |                                   |  |
|                     | 100  | ē                | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c. |  |                           |                                  |                                |                         |                             |                          | -   |                         |  |                                   |  |
|                     | uted<br>d<br>ansit   | Examiner         |  |  |                           |                                  |                                |                         |                             |                          |   |                         |  |                                   |  |
| ó                   | an an<br>rial-tr   | Exa              | resulting in death) Last   | Due to (or as                                  | a conseq                  | uence of):                       |                                |                         |                             |                          |   |                         |  |                                   |  |
| 8760,               | The law requires that the death certificate be executed tie has been signed by the attending physician and cage 2 should be detached for use as the burial-transit       | Ical             |  | d  |                           |                                  |                                |                         |                             |                          |   |                         |  |                                   |  |
| 9                   | eath certifica<br>attending phi<br>I for use as th   | Med              | IF FEMALE:   |  |                           |                                  |                                |                         |                             |                          |   | I                       |  |                                   |  |
| Вох                 | ath ce   | lan/             | 23b. Was decedent pregnant in the past 12 months?  | 23c. If yes, outcome<br>1 ☐ Live birth         | 2 Feta                    | Ideath 3                         | Ectopic pre                    |                         |                             |                          |   | 23                      | d. Date of delive                                  | very<br>Day Year                  |  |
| 0.                  | at the de<br>by the a<br>tached f  | yslc             | 1   Yes 2   No 9   Unknown 9   Unknown 9   Unknown 230 Did tobacce use styles in Boat II.  |  |                           |                                  |                                |                         |                             |                          | Wichth  |                         |  |                                   |  |
| <u>α</u>            | that the   |                  |  |  |                           |                                  |                                |                         |                             | contribute to            | te to the cause of death?                               |                         |  |                                   |  |
| ds,                 | uires<br>sign<br>Id be   | d by             | Prostate Cancer  |  |                           |                                  | , ,                            |                         |                             |                          |   |                         |  | bably 4 Unknown                   |  |
| SO                  | w requir<br>been si<br>should  | lete             | Diabetes Mellit  | 1119   |                           |                                  |                                |                         |                             |                          | 24a. Was a  | n                       | 24h Were aut                                       | oney findings available           |  |
| Records,            | The lay  | Completed        | Diabetes herricus  |  |                           |                                  |                                |                         |                             | autops                   | autopsy prior to completion of cau<br>performed? death? |                         |  |                                   |  |
| Vital               |  | ပိ               | Atrial Fibrilla 25. Was case referred to medical   | ition  |                           |                                  |                                |                         | 26 Place                    | of Doath                 | (Check only on  | 2 ☑ No                  | 1 🗆 Yes  | 2 No                              |  |
| <u>&gt;</u>         | S S D  | To B             | examiner?<br>1 ☐ Yes 2 🛣 No  | Hospital:                                      | ent 2 🗆                   | ER/Outpatier                     | nt 3 DOA                       | A Othe                  |                             |                          | ne 5□Reside   |                         | Other (Spec  | Asst.                             |  |
| J Of                | ding Ph<br>h.<br>After th<br>funeral   |                  | 27. Manner of Death  | 28a. Date of Inju<br>(Month, Da                | ry<br>v Year)             | 28b. Time o                      |                                | Bc. Injury<br>Work      |                             |                          | 28d. Describe ho  |                         |  | Living                            |  |
| <u>io</u>           | Attending r death. sctor: After by the funer   | atic             | 1 XNatural 5 ☐ Pending 2 ☐ Accident investigation  |  | mjury                     | M 1 Yes 2 No                     |                                |                         | No                          |                          |   |                         |  |                                   |  |
| Division            | or Attendated after death<br>Director:   | Certification;   | 3 ☐ Suicide 6 ☐ Could not be<br>4 ☐ Homicide determined  | 28e. Place of Inj<br>building, et              | ury - At he<br>c. (Specif | ome, farm, sti<br>y)             | reet, factory,                 | office                  |                             | 2                        | 28f. Location (St<br>City or Town                       | reet and i              | Number or Rui                                      | al Route Number,                  |  |
|                     | itai o<br>rrs af<br>ral D  |                  |  |  |                           | ·                                |                                |                         |                             |                          |   |                         | ÷  |                                   |  |
|                     | within 24 hours after To the Funaral Directory Completely filled in b  | Medical          | 29a. Certifier 1 ☑ Certifying Ph: (Check only 2 ☐ Medical Examone)   | ysician: To the best<br>liner: On the basis o  | f examina                 | wledge, deat<br>ition and/or in  | h occurred a<br>vestigation, i | at the tim<br>in my op  | e, date and<br>pinion, deat | d place, a<br>th occurre | and due to the cared at the time, d                     | ause(s) ar<br>ate and p | nd manner as :<br>lace, and due !                  | stated.<br>to the cause(s)        |  |
|                     | To the within 2 To the complet   | Med              | 29b. Signature and title of certifier  | and manner st                                  | ateo.                     |                                  | 29c.                           | License                 | number                      |                          | 2   | 9d. Date :              | signed (Month,                                     | Day Year)                         |  |
|                     | 1  |                  |  | ry De  | ee                        | 5                                | 1200                           |                         | 0191                        | 92                       |   |                         | ber 7,   |                                   |  |
|                     | 6  |                  | 30. Name and address of person who o   |  |                           |                                  | Print)                         |                         |                             | -                        |   |                         |  |                                   |  |
|                     |  |                  | Barry Hecht, MD,   |  |                           |                                  |                                | ton,                    | , Mary                      | y1an                     | d 20906   |                         |  |                                   |  |
|                     | . Sta  | ite              | 31. Date filed (Month, Day, Year)  |  |                           |                                  |                                |                         |                             |                          |   |                         |  |                                   |  |
|                     | Regist   | rar              | DEC 0 9 20   | 105  | U K                       | ature A                          |                                |                         |                             |                          |   |                         |  |                                   |  |

| Baltimore, Maryland 21215-0036             | permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "naturel", or Items 23e or 28e-1 show any injury or either treumatic event, the Medical Evanfriet must be in-tilling at                                    |
|--|--|
| Division of Vital Records, P.O. Box 68760, | To the Hospital or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death.  To the Funerel Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit |

Funeral Director

|  | State Registrar  |  |   |  | Ce  | artment of<br>artificate o   | f Dea  | th                      |  | Reg. N   | . 0 0   | J  | 4101   |  |
|--|--|--|---|--|---|--|--|-------------------------|--|--|---|--|--|--|
|  | 1. Decedent's Name (   | (First, Middle,  | , Last)   |  |   |  |  |                         | 2. Date of De  | eath   |   |  | 3. Time of   |  |
| ın   | Walter E   | E. Kenr  | nedy  |  |   |  |  |                         | Decemb   | er   | 4, 20   | 005°   | 3:10   |  |
| al<br>er   | 4a. Facility Name (If n  |  |   | mber)  |   | 4b. City, Town   | n, or Locati   | ion of Death            |  |  |   | of Death   | 1  |  |
|  | Holy Cros  | s Hosp   | oital   |  |   | Silve  |  |                         |  | 1  | Montg   | gomer  | У  |  |
|  | 5. Social Security Nun   |  | 6. Sex<br>1 M 2 F   | 7. Age (In yrs.  |   | ) If Under 1 Ye<br>Months Day  |  | ider 24 Hrs.            | 8. Date of Bi  | av. Yea  | r)  | 9. Birthp  | place (State o   |  |
|  | 414-40-55  |  | N Z   | 86   | Yrs.  |  |  |                         | Feb. 2   | 2,   | 1919  | Ten  | nessee   |  |
| +  | Usual Residence of D<br>10a. State   | 10b. County  |   | 10c. Cit   | y, Town or L  | ocation  |  |                         |  |  |   | 1  | 10d. Inside Ci   |  |
| 6  | D.C.   | N/A  |   | T.I  | ashing  | rton   |  |                         |  |  |   |  | X Yes  |  |
| Director   | 10e. Street and Numb   |  | -   | 10f. Zip Code  | Α   |  |  | 10a C                   | Citizen of V   | What Cour  | ntry?   |  |  |  |
|  | 65 Underw  | twoot N  | 2001  |  |   |  |  | itizen of What Country? |  |  |   |  |  |  |
| erai   | 11. Marital Status   | vood si  | 12. Was Dec   | edent Ever in U  | .S. 13.   | Was Decedent of  | of Hispanic  | Origin? (Sp             | ecify Yes or N   |  | Jnited States  14. Race - American Indian,  |  |  |  |
| Funer  | 1 Never Married  | d 2[X]Marrie   | ed 1 XYes   |  | •   | If Yes, specify C  |  |                         | Rican, etc.)   | i  | Blad  | ck, White,   | etc.   |  |
| by   | 3 ☐ Widowed 4  | Divorced   | If Yes, Gir<br>Year or D  | ve<br>lates:   |   | 1⊡Yes 24⊡N   | No Spec  | city:                   |  |  | Specifi<br>Afri   | y:<br>Lcan   | Americ   |  |
| ompleted   | 1<br>(Specify  | 15. Decedent'  | s Education<br>t grade completed)   |  | 16a. Dece   | edent's Usual Oct  | cupation   | most of work            | ina  | 16b.   | Kind of B   | usiness/In   | dustry   |  |
| nple   | Elementary/Second  |  | College (   | 1-4or 5+)  | life.   | DO NOT use ret   | tired)   | most of work            | y  |  |   |  |  |  |
| 0 -  |  |  | ·   | +  | Soci  | Lal Work   |  |                         |  | 1 -  |   | overn  | ment<br>nk.  |  |
| m  | 17. Father's Name (Fi  | rirst, Middlə, L   | last) ulik•   |  |   |  | 18. M  | other's Nam             | e (First, Middle   | , Maide  | an Suman  | пө) ч  | .11K •   |  |
| ٥.   |  |  |   |  | 11  |  |  |                         |  |  | _   |  |  |  |
|  | 19a. Informant's Nam   |  |   | ,  |   | ling Address <i>(Stre</i><br>nderwood  |  |                         |  | -  |   |  |  |  |
|  | Mary E. K  | <u>.</u>   | A (MTIE   | <del></del>  | -   |  |  | .,                      |  | _  | _   |  | 20012  |  |
|  | 1X Burial 2 □ Cremation 3 □ Removal from State cemetery, crematory or other place)   |  |   |  |   |  |  |                         |  |  |   | - City or Town, State  |  |  |
|  | *4 □Donation 5<br>21. Signature of Fune  |  |   | Man  |   | Nationa  |  | 12/9                    |  | Lau  | rel,  | Mar  | y1and  |  |
| 4,400  | 22. Name and Address of Facility MCGuire Funeral Service 7400 Georgia Ave. N.W., Washington, D.C. 20  23a. Part1. Enter the disease, or complications that chused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death Immediate Cause (Final  |  |   |  |   |  |  |                         |  |  |   |  |  |  |
| 9 III  | disease or condition   |  | _   |  | n. Do not en  | nter the mode of c   | tying, such  | as cardiac              | or respiratory a   | arrest,  |   | 4  | Onset and I  |  |
| Exai   |  | ditions,<br>necrate<br>ying<br>ijury   | a. Se Due to b. Ad Due to c.  | <b>psis</b><br>(or as a conseq   | uence of): pirato uence of):  | ory Dist   | <u></u>  |                         |  | arrest,  | -   |  | Interval Bety  |  |
| hysician/Medical   | disease or condition resulting in death)  Sequentially list conditions, leading to immicause. Enter Underly Cause (Disease or in that initiated events   | ditions, included ying ying july asst  | a. Se Due to b. Ad Due to c. Due to d   | psis (or as a consequant Res (or as a consequant accomed for a consequence for a conseque | pirate of): pirate of): uence of): uence of):   |  | ress   |                         |  | arrest,  |   | te of delive   | Interval Beb<br>Onset and t<br>6 Wee   |  |
| ed by Physician/Medical                                    | disease or condition resulting in death)  Sequentially list cond if any, leading to infricause. Enter Underly Cause, Disease or in that initiated events resulting in death) La  IF FEMALE: 23b. Was decedent print the past 12 mm 1 mm 4 mm 12 mm 1 mm 4 mm 12 mm 1 mm 4 mm 12 mm 1 mm 1  | ditions, induitions, induition | a. Se Due to b. Ad Due to c. Due to d. 23c. If yes, out 1 Live to 4 Pregr   | psis (or as a consequant Res (or as a consequant at time of down   | uence of):  pirato uence of):  uence of):  ancy I death 3( eath 5(  | □Ectopic pregna  | ress   | Syndro                  | ome<br>23e. Did  | tobacco  | Mo<br>use cont  | onth<br>tribute to th  | Interval Bett Onset and to 6 Wee   |  |
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State of Maryland / Department of Health and Mental Hygiene 15 1 - For Stata Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** mastasia awec 2005 08 10:38A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Homewood at Crumland Farms Frederick Frederick 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sax 7. Age (In yrs. last birthday) Birthpface (State or Foreign Country) **Funeral** 1□M 2**X**1F Days Hours 291-14-9364 82 Yrs. Director Ohio Usual Residence of Decedent 10c. City, Town or Location 10a State 10b County 10d. Inside City Limits 7 is marked other then "naturel", or Items 23a or 28e-f show traumatic event, the Medical Examinations in the molified at 1 XYes 2 No Directo Maryland Frederick Frederick 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 7400 Willow Road 21702 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-ff Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bfack, White, etc. 11. Marital Status filed within 72 hours after 1 Never Married 20X Married Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: White þ Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 2 should be fi and Mental H Dans Nicholas Anna Schubert 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2: Department of Health ar Importent: If Item 27 is any injury or other trau QDGs. Carolyn Kawecki/Daughter 4822 Ed. McClain Road, Monrovia, MD 21770 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🙀 Burial 2 □ Cremation 3 □ Removal from State St. John's Cath Cem 12/12/2005 \*4 ☐ Donation 5 ☐ Other (Specify) Frederick, MD 22. Name and Address of Facility Stauffer Funeral Home, PA 21. Signature of Funeral Service Licensee 1621 Opossumtown Pike, Frederick, MD 21702 ounthey 23a. Part1. Enter the disea of or complications train aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause an ach line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician 10m disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examine Cause (Disease or injury that initiated events resulting in death) Last certificate be executed physician and strans the burial-trans Due to (or as a consequence of): Physician/Medical IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? ò Month Year 4☐Pregnant at time of death Day 5 Other (specify) Ö the 9 Unknown þ ۵. signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ INV 2X No 1 🗌 Yes 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 certificate has autopsy performed? Yes 21 No No 1 Yes Vital 1 Yes 25. Was case referred to medical director 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 Other: 2 1 🗌 Yes Nursing Home 5 Residence 6 Other (Specify) ō this funeral 28a. Date of Injury (Month, Day Year) Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After Division Hospital or Attending 1 Natural 2 Accident 5 Pending death. 1 Tes 2 No investigation Director: in 24 hou...
the Funerel Dire... 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0 D0060 417 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hemen Shah 1 homas 2005 12 Registrar

|             |  |                | 1- State of Maryland / Depa  | artment of Health and M<br>tificate of Death  | lental Hygie  |  | 41607  |                      |                     |
|-------------|--|----------------|--|---|---|--|--|----------------------|---------------------|
|             |  |                | Decedent's Name (First, Middle, Last)  | 77.77   | 2. Date of Death<br>Month   | Day Year                                   | 3. Time of Death                                   |                      |                     |
|             | Physici<br>/Medio  |                | Doris Catherine Keyser   |   | December  | 9, 2005                                    | 12:30 a M  |                      |                     |
|             | Examin   |                | 4a. Facility Name (If not institution, give street and number)  Carroll Lutheran Village Health Care   | 4b. City, Town, or Location of Death Westminster  |   | 4c. County of Deat Carrol                  |  |                      |                     |
|             | Funeral  |                | 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)  | If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.  | 8. Date of Birth<br>(Month, Day, Ye   | 9. Birt                                    | nplace (State or Foreign untry)                    |                      |                     |
|             | Director   |                | 218-07-5837 1□M 2젗F 87 Yrs.  |   | Feb 5, 19   |  | land   |                      |                     |
|             | and  | 1              | Usual Residence of Decedent           10a. State         10b. County         10c. City, Town or Lo.  | cation  |   |  | 10d. Inside City Limits                            |                      |                     |
|             | Mary<br>First  | to             | Maryland Carroll Westm   | inster  |   |  | 1 XYes 2 □ No                                      |                      |                     |
|             | h the  | Director       | 10e. Street and Number   | 10f. Zip Code   | 10g.  | Citizen of What Co                         | untry?   |                      |                     |
|             | 23a  | aic            | 250 St. Luke Circle #704   | 21158   |   | USA  |  |                      |                     |
| 36          | 72 hours after death with the Maryland<br>natural', or items 23a or 28a-f show<br>Alcel Examinan must be notified at | by Funeral     | Armed Forces? If   | Nas Decedent of Hispanic Origin? (Spi<br>1 Yes, specify Cuban, Mexican, Puerto<br>I ☐ Yes 2 ☑ No Specify: | ecify Yes or No-<br>Rican, etc.)  | 14. Race - Ame<br>Black, White<br>Specify: |  |                      |                     |
| 21215-0036  | 72 hours<br>"natural",   | ted            | 15. Decedent's Education 16a. Deced  | lent's Usual Occupation   | 165   | o. Kind of Business/                       |  |                      |                     |
| 215         | be filed within 72 ho<br>tal Hygiene<br>d other than "natu   | Completed      | (Specify only highest grade completed) (Give life. L   | kind of work done during most of work.<br>DO NOT use retired)   | ng  |  |  |                      |                     |
|             | ed wi  | Con            |  | maker   |   | Own Hom                                    | 9  |                      |                     |
| Maryland    |  | To Be          | 17. Father's Name (First, Middle, Last)  Fdwin Gilmore Zimmerman, Sr.  | 18. Mother's Name   | e (First, Middle, Maio<br>affman  | den Sumame)                                |  |                      |                     |
| ary         | ges 1 and 2 should<br>t of Health and Men<br>if item 27 is marke<br>or other traumatic                               | -              |  | g Address (Street and Number or Rura  |   | ity or Town, State, 2                      | ip Code)   |                      |                     |
|             | es 1 and 2<br>of Health a<br>fitem 27 is<br>r other tra  |                | LUATIES N. NEVSEL DUSCALO  | t. Luke Cir. #704   | Westmins  | ster, MD                                   | 21158  |                      |                     |
| ore         | of He  |                | 20a Method of Disposition 20b, Place of Disposition  | sition (Name of natory or other place)  | Date 20c  | . Location - City or                       | Town, State  |                      |                     |
| Ě           | Pag<br>ment<br>ant:  |                | `4 □Donation 5 □Other (Specify) Woodlawn   | Cemetery 12/12  | 2/2005 W  | oodlawn, 1                                 | Maryland   |                      |                     |
| Baltimore,  | permit. Pages 1<br>Department of H<br>Important: if ite<br>any njury or otl  |                |  | ritts finefallyHom<br>12 Washington Road  |   |  | 21157  |                      |                     |
|             | Physician<br>/Medical<br>Examiner  |                | 23a. P/r.1. Enter the disease, or com/lications the used the death. Do not enter nock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. Due to (or as a consequence of the consequence of th | er the mode of dying, such as cardiac.  However, I was a such as cardiac.                                 | respiratory arrest,   | 2  | Approximate<br>Interval Between<br>Onset and Death |                      |                     |
| 8760,       | cate be executed by sician and the burial-transit  | dicai Examiner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  b. Due to (or as a consequence of):  c   |   |   |  |  |                      |                     |
| O. Box 6    | the death certific<br>y the attending p<br>iched for use as  | Physician/Med  |  | Ectopic pregnancy Other (specify)   |   | 23d. Date of deli<br>Month                 | very<br>Day Year                                   |                      |                     |
| <b>a</b>    | w requires that<br>been signed b<br>should be deta   | by             | by   | þ   | Part II. Other significant conditions contributing to death but not resulting in the un | nderlying cause given in Part I.           | 23e. Did tobace                                    | co use contribute to | the cause of death? |
| Il Records, | The law<br>ate has b<br>page 2 st  | Completed      |  |   | 24a. Was an autopsy performed   | prior to death?                            | topsy findings available completion of cause of    |                      |                     |
| Vital       |  | o Be           | 25. Was case referred to medical examiner?  1   Yes 2   The Hospital: 1   Inpatient 2   ER/Outpatien   | Othor \   | (Check only one)  |  |  |                      |                     |
| of          |  |                | 27. Manner of Death 28a. Date of Injury 28b. Time of   | 28c. Injury at  | me 5 Residence  |  | erfy)  |                      |                     |
| on          | Attending F<br>r death.<br>sctor: After<br>by the funer  | ation          | TSSSSSSSSSSSSSSSSSSSSSSSSSSSSSSSSSSSS  | Work?<br>M 1 ☐ Yes 2 ☐ No   |   | . ,  |  |                      |                     |
| Division of | ai or Attendi<br>: after death.<br>i Director: A<br>d in by the fu   | Certification: | 3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of Injury - At home, farm, street building, etc. (Specify)   | eet, factory, office  | 28f. Location (Stree<br>City or Town, S   | t and Number or Ru<br>tate)                | ral Route Number,                                  |                      |                     |
|             | To the Hospital or Attenwithin 24 hours after death To the Funeral Director:   | edicai C       | 29a. Certifier  (C   | restigation, in my opinion, death occurr  | ed at the time, date  | e(s) and manner as<br>and place, and due   | stated.<br>to the cause(s)                         |                      |                     |
|             | To the To the To the comp  | Me             | 29b. signature and title of certifier  | 29c. License number   | 29d.  | Date sized (Moght                          | n, Day, Year)                                      |                      |                     |
|             | IN   |                | Freunto DO   | 4003584   | 43 10   | 2/9/21                                     | 005  |                      |                     |
|             | W3   |                | 30. Name and address of person who completed cause of death (Item 23a) (Type.  | Print) POALE  | Rd. W   | ESTAI                                      | NS/EX,   |                      |                     |
|             | Sta<br>Regist  |                | 31. Date filed (Month, Day, Year) 32. Registrar's Signature DEC 0 9 2005   | 29c. License number  #205584  Print)  886 F00LE /   | 1   |  | 110/   |                      |                     |

|                     |   |              | 1 - For<br>State<br>Registrar  | State               | of Maryla  |   | artment of H   |                                  | nd Mental Hy                                 | giene<br>Reg. No.                  | 005  | 41608  |  |
|---------------------|---|--------------|--|---------------------|--|---|--|----------------------------------|--|------------------------------------|--|--|--|
|                     | Physici   |              | Decedent's Name (First, Middle FREDERICK   |                     | HRER   |   |  |                                  | 2. Date of De<br>Month<br>Decembe            | Day                                | Year<br>2005   | 3. Time of Death 12:15 A <sup>M</sup>              |  |
|                     | /Medic<br>Examin  |              | 4a. Facility Name (If not institution  | n, give street and  | i number)  |   | 4b. City, Town, or   | Location of E                    |  |                                    | County of Death  | 12.13 A  |  |
|                     |   |              | Bedford Court  | Nursing             | Home   |   | Silver   | Spring                           | g  | Mo                                 | ntgomery   | 7  |  |
|                     | Funeral<br>Director   |              | 5. Social Security Number 121–03–3649  | 6. Sex<br>1 X M 2 □ |  | rs. last birthday)<br>5 Yrs.              | If Under 1 Year<br>Months Days                                     | If Under 24<br>Hours             | Min. 8. Date of Bin<br>(Month, Da<br>Feb 8   | 1919                               | 9. Birthp<br>Cour<br>New Y   | place (State or Foreign<br>htry)<br>York           |  |
|                     | and *   |              | Usual Residence of Decedent  10a. State 10b. County  |                     | 100  | City, Town or Lo                          | ocation  |                                  |  |                                    |  | 0d. Inside City Limits                             |  |
|                     | f sho   | ō            | ,  |                     | 1  |   |  |                                  |  |                                    |  | 1 ☐ Yes 2 🛣 No                                     |  |
| 36                  | the 28a-  | Director     | MD         Montgomery         Silver Spring           10e. Street and Number         10f. Zip Code         10g. Citizer  |                     |  |   |  |                                  |  |                                    | en of What Cour  | ntov?  |  |
|                     | leath with  | Funeral Di   | 3310 No. Leisure World Blvd #316  10. Zip Code  10g. Citizen of Vic. Zip Code  10g. Citizen o |                     |  |   |  |                                  |  |                                    | d States   | tates<br>ce - American Indian,                     |  |
|                     | urs after o<br>al', or Itan   | by           | 1 Never Married 2√ Marri<br>3 Widowed 4 Divorced   | ried 1 7 Y          | d Forces?<br>es 2 □ No W<br>, Give W<br>or Dates:        | JTT                                       | lf Yes, specify Cuba<br>1 ☐ Yes 2 ☑ No                             | n, Mexican, P<br>Specify:        | Puerto Rican, etc.)                          |                                    | Black, White,  |  |  |
| Maryland 21215-0036 | within 72 hours after death with the Maryland<br>nne.<br>than 'natural', or Itams 23a or 28a-f show<br>Ita Maziloti Examirer must be notified at  | Completed    | 15. Deceden (Specify only higher Elementary/Secondary (0-12)   |                     | ed)<br>ge (1-4or 5+)                                     | (Give                                     | dent's Usual Occupa<br>kind of work done of<br>DO NOT use retired, | luring most of                   | f working                                    | 16b. Kin                           | d of Business/Inc  | dustry   |  |
| 1d 21               | e filed with<br>Il Hygiene<br>other the<br>rent, Ille   | e e          | 17. Father's Name (First, Middle,  |                     | 4  | A   | uditor   | 18. Mother's                     | Name (First, Middle,                         |                                    |  | Government   |  |
| /lar                | uld be<br>Menta<br>rrked<br>ric a   | To B         | David Lehrer   |                     |  |   |  | Bessi                            | ie Mushkat                                   | blut                               |  |  |  |
| lar                 | 2 sho<br>and h<br>is ma   |              | 19a. Informant's Name/Relations  | hip (Type, Print)   |  | 19b. Mailir                               | ng Address (Street a   | ind Number o                     | or Rural Route Numbe                         | er, City or                        | Town, State, Zip   | Code)  |  |
| Baltimore, Ma       | permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural; or Itams 23a or 28a-f show among injury or other traumatic avent, It a Macical Examination and once. |              | Beverly Lehrer  20a. Method of Disposition  1X Burial 2 Cremation  |                     | 206  | 221<br>. Place of Dispo<br>cemetery, cree | 2 Washing<br>sition (Name of<br>matory or other place              | ton Av                           | #104,_S                                      | ilver<br>20c. Loc                  | Spring<br>ation - City or To   | MI) 20910<br>wn, State                             |  |
| Ë                   | Pag<br>tment<br>tant:   |              | ' 4 □ Donation 5 □ Other (S  | pecify)             |  |   |  |                                  | -09-2005                                     |                                    |  |  |  |
| Ba                  | Depar<br>Depar<br>Impor<br>any ir   |              | 21. Signature of Funeral Service   | ( Oa                | Dem  | 11  | 800 New H  | lampshi                          | ire Ave Si                                   | lver                               |  | Home, Inc.<br>MD 20904                             |  |
|                     |   |              | O D  |                     |  |   |  |                                  |  |                                    |  | Approximate<br>Interval Between<br>Onset and Death |  |
|                     | Pnysician<br>/Medical   |              | Immediate Cause (Final disease or condition resulting in death)  | a.                  | zheimer  |   | ase  |                                  |  |                                    |  |  |  |
| ř                   | Examiner  |              | Due to (or as a consequence of):   |                     |  |   |  |                                  |  |                                    |  |  |  |
|                     | 7 =   | ner          | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of):  |                     |  |   |  |                                  |  |                                    |  |  |  |
|                     | ecuter<br>and<br>-trans   | Examiner     | cause. Enter Underlying Cause Ciscate or injury that initiated events resulting in death) Last  Due to (or as a consequence of):   |                     |  |   |  |                                  |  |                                    |  |  |  |
| 8760,               | cate be executed<br>physician and<br>the burial-transit   |              |  |                     |  |   |  |                                  |  |                                    |  |  |  |
| 687                 | ficate<br>physis the  | edicai       |  | d                   |  |   |  |                                  |  |                                    |  |  |  |
| .O. Box             | he death certific<br>the attending p  | Physician/Me | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒No 9 ☐ Unknown   | 1 ☐ Liv<br>4 ☐ Pr   | outcome of preg<br>ve birth 2 Preg<br>regnant at time on | etal death 3                              | Ectopic pregnancy Other (specify)                                  |                                  |  | 23                                 | 3d. Date of delive<br>Month  | ory<br>Day Year                                    |  |
| ٥.                  | res that the de<br>igned by the a<br>be detached t  |              |  | ons contributing t  | o death but not r  | esulting in the u                         | nderlying cause give   | n in Part I.                     | 23e. Did to                                  | bacco use                          | e contribute to th   | e cause of death?                                  |  |
| ords,               | The law requires that the tee has been signed by the bage 2 should be detache   | Completed by | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  Cerebrovascular Insufficiency  |                     |  |   |  |                                  |  | 1 Yes 2√C3No 3 Probably 4 Unkr     |  |  |  |
| Vital Record        |   |              |  |                     |  |   |  |                                  | 24a. Was :<br>autop<br>perfor<br>1 □ Yes     | sy                                 | 24b. Were autop<br>prior to con<br>death?<br>1 \( \sum \text{Yes} \) | osy findings available npletion of cause of 2 No   |  |
| Vita                | Physician: The this certificate al director, pag  | Be           | 25. Was case referred to medical examiner?   | Hospital            |  |   | Othe   |                                  | Death (Check only o                          |                                    |  |  |  |
|                     |   | - To         | 1 ☐ Yes 2 ☑ No<br>27. Manner of Death  | 1                   | ☐ Inpatient 2<br>ate of Injury                           | ☐ ER/Outpatien<br>28b. Time of            | The second second  | 4 XIVUISII                       |  | Home 5 Residence 6 Other (Specify) |  |  |  |
| On                  | Attending r death. sctor: After by the funer  | tion         | 27. Manner of Death 1 ★ Natural 5 Pending investigation 3 ★ Suicide 4 ★ Homicide 28a. Date of Injury 28b. Time of Injury 4 Work? Month, Day Year) 28b. Time of Injury 4 Work? M 1 ★ Yes 2 No 28d. Describe how injury occurred Injury M 1 ★ Yes 2 No 28d. Describe how injury occurred 1 ★ Yes 2 No 28d. Describe how injury occurred 28d. Describe how i  |                     |  |   |  |                                  |  | occurred                           |  |  |  |
| Division of         | i Diffic  | ertifica     |  |                     |  |   |  |                                  |  | treet and in, State)               | Number or Rural  | Route Number,                                      |  |
|                     | HQ<br>HQ<br>HQ<br>HQ<br>HQ  | edical C     | 29a. Certifier (Check only one)  1 Certifyin 2 Medical   | Examiner: On th     | the best of my k<br>e basis of exami<br>nanner stated.   | nowledge, death<br>nation and/or inv      | n occurred at the time<br>restigation, in my op                    | e, date and pi<br>inion, death o | lace, and due to the occurred at the time, o | ause(s) a                          | nd manner as sta<br>place, and due to                                | ated.<br>the cause(s)                              |  |
|                     | To tha within 2. To tha complet   | Me           | 29b. Signature and title of certifie   | ſ                   | 111  |   | 29c. License   | number                           | 2  | 9d. Date                           | signed (Month, E   | Day, Year)   |  |
|                     | di  |              | 1 the  | , ~                 | ~  |   | D0035  | 045                              |  | Decem                              | mber 8,  | 2005   |  |
|                     | 1   |              | 30. Name and address of person Philip G. Henj  | •                   | -  |   |  | ive #7                           | 200. Olpay                                   | MD                                 | 20832  |  |  |
|                     | Sta   | te           | 31. Date filed (Month, Day, Year)  |                     | Registrar's Sig  |   |  | 140 112                          | ou, orney                                    | , ru                               | 20032  |  |  |
|                     | Registr   | -            | DEC 0 9  | 2005                | Jus B  | nature                                    |  |                                  |  |                                    |  |  |  |

|                     |  |                | 1 - For<br>State<br>Registrar Amend #17  | State of Ma                           |                  | -         |   |                 |                | ntal Hygie                       | 2000                          | 41609   |
|---------------------|--|----------------|--|---------------------------------------|------------------|-----------|---|-----------------|----------------|----------------------------------|-------------------------------|---|
|                     |  | 2.             | 1. Decedent's Name (First, Middle, Last)   | )                                     | 10-200.          | J- 61     | VIVI. COLIC C.                              |                 | 2.             | Date of Death                    |                               | 3. Time of Death                                    |
|                     | Physici  |                | SOON NAM LEE   |                                       |                  |           |   |                 |                | Month<br>ECEMBER                 | 8 2005                        | 4:42 P M  |
| 1                   | /Medic<br>Examin   |                | 4a. Facility Name (If not institution, give  | street and number)                    |                  |           | 4b. City, Town, or                          | r Location o    |                |                                  | 4c. County of Dea             |   |
|                     |  |                | FREDERICK MEMOR  | IAL HOSPI                             | ral .            |           | FREDERI                                     | CK              |                |                                  | FREDERIC                      | CK  |
|                     | Funeral  |                | Social Security Number     6. Security Number                                      | 7. Age                                | (In yrs. last bi |           | If Under 1 Year<br>Months Days              | If Under:       |                | Date of Birth<br>(Month, Day, Ye | 9. Bi                         | rthplace (State or Foreign<br>country)              |
| X                   | Director   |                | 210-40-3/12  | JM 2(2)FF                             | 71               | Yrs.      |   |                 |                | ov. 19,                          | - (                           | orea  |
|                     | and *  |                | Usual Residence of Decedent  10a. State 10b. County                                |                                       | 10c. City, Tow   | n or Lo   | cation                                      |                 |                |                                  |                               | 10d. Inside City Limits                             |
|                     | dary!<br>f aho   | ō              | Maryland Frederic  | ·k                                    | Brur             |           |   |                 |                |                                  |                               | 11√2 Yes 2 □ No                                     |
|                     | 28a-   | Director       | 10e. Street and Number   |                                       |                  |           | 10f. Zip Code                               |                 |                | 100                              | Citizen of What C             | ountry?   |
|                     | with<br>the  |                |  |                                       |                  |           |   |                 |                |                                  |                               | ,   |
|                     | na 2;  | Funerai        | 808 6th Ave.   | 12. Was Decedent E                    | ver in U.S.      | 13. V     | 21716 Was Decedent of H f Yes, specify Cuba | ispanic Orio    | gin? (Specify  |                                  | ited Sta                      |   |
| G                   | r Ite  | 교              | 1 ☐ Never Married 2 ☐ Married  | Armed Forces?<br>1 ☐ Yes 2 🛣 No       | 0                |           |   |                 |                | an, etc.)                        | Black, Wh                     |   |
| ğ                   | ral', o  | by             | 3 ☐ Widowed 4 🏋 Divorced   | If Yes, Give<br>Year or Dates:        |                  | 1         | I□Yes 2X No                                 | Specify:        |                |                                  | Specify: A                    | sian  |
| 5-0                 | 72 hc  | Completed by   | 15. Decedent's Edu<br>(Specify only highest grade                                  | cation<br>e completed)                | 16a              | . Deced   | lent's Usual Occup                          | ation           | t of working   | 168                              | . Kind of Busines:            | s/industry  |
| 2                   | nithin<br>Nan  | idr            | Elementary/Secondary (0-12)  | College (1-4or 5-                     | -)               |           | kind of work done of<br>OO NOT use retired  | 3)              |                |                                  |                               |   |
| 2                   | led w<br>lygier<br>her ti  | S              | 12   |                                       |                  | C1        | erk   |                 |                |                                  | Insuran                       | ce  |
| and                 | be fr  | Be             | 17. Father's Name (First, Middle, Last)  | Mal Van                               | na Chur          | . ~       |   | 18. Mothe       |                | rst, Middle, Mai                 | ·                             |   |
| 2                   | d Mer<br>nark  | 2              | Mal Young Chun   | Mal You                               |                  |           |   |                 |                | Nam Kim                          |                               |   |
| Maryland 21215-0036 | 12 st<br>th and<br>7 Is r  |                | 19a. Informant's Name/Relationship (Ty   |                                       | 196              | o. Mailin | g Address (Street a                         | and Numbe       | er or Hural Ho | oute Number, C                   | ity or Town, State,           | Zip Code)   |
|                     | 1 and<br>Heali   |                | Sonia Domarasky / 20a. Method of Disposition                                       | Daughter                              | 20b. Place o     | of Dispo: | East A S                                    | - 1             | Brunsw<br>Date |                                  | 21716<br>:. Location - City o | r Town State  |
| 0                   | ages<br>int of<br>t: If it   |                | 1 Burial 2 Cremation 3 R   | Removal from State                    |                  |           | Cremator                                    | 1               | 12/12/         |                                  | ,                             | , Maryland  |
| Baltimore,          | permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or Itema 23e or 28e-f ahow any figury or other traumatic avent, the Medical Examiner mail by multiple at Annes. |                | 4 ☐ Donation 5 ☐ Other (Specify)  21. Signatur® of Funeral Service License         | <br>AA                                | riedei           |           | . Name and Addres                           |                 |                |                                  | rederick<br>uneral Ho         |   |
| Ba                  | Depa<br>Impo<br>any I  |                | Mindred  | toullas                               |                  |           | 1100 Nort                                   |                 |                |                                  |                               |   |
|                     | 4  |                | 23a. Rant. Enter the disease, or complishock, or heart failure. List only or       | ications that caused to               | the death. Do    |           |   |                 |                |                                  |                               | Approximate   |
|                     | Physician  |                | Immediate Cause (Finaf   |                                       |                  |           |   |                 |                |                                  |                               | Interval Between<br>Onset and Death                 |
| )                   | /Medical   |                | disease or condition resulting in death)   | Due to for as a                       | CODSCIUDED       | 00:       | nfarcti                                     | Un              |                |                                  |                               | MINUHS  |
|                     | Examiner   |                |  | huser                                 | Ensive           | 0         | nfarcti                                     | d1.500          | 150            |                                  |                               | upars   |
|                     |  | Jer            | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying | Due to (or as a                       |                  |           | , 200 11                                    |                 |                |                                  |                               | /20(1.3   |
|                     | cuted  | Examiner       | Cause (Disease or injury that initiated events                                     | s                                     |                  |           |   |                 |                |                                  |                               |   |
| Ó,                  | e exe<br>ien a<br>urial-l  | Ĕ              | resulting in death) Last   | Due to (or as a                       | consequence      | of):      |   |                 |                |                                  |                               |   |
| 8760,               | Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physicien and rail director, page 2 should be detached for use as the burial-transit  | lical          |  | d                                     |                  |           |   |                 |                |                                  |                               |   |
| 9                   | leath certifica<br>attending ph<br>if for use as ti  | Physician/Med  | IF FEMALE:   |                                       | . 5761           |           |   |                 |                |                                  |                               |   |
| Вох                 | ath c  | ian/           | 230. Was decedent pregnant   | 3c. ff yes, outcome o                 | ! Fetal death    |           | Ectopic pregnancy                           |                 |                |                                  | 23d. Date of de<br>Month      | livery<br>Day Year                                  |
| P.0.                | res that the designed by the a   | ysic           | in the past 12 months? 1 ☐ Yes 2 D No 9 ☐ Unknown                                  | 4□Pregnant at t<br>9□Unknown          | ime of death     | 5 🗀       | Other (specify)                             |                 |                |                                  |                               | ou, ou  |
|                     | that the by detac  | P.             | Part II. Other significant conditions cor  | ntnbuting to death but                | not resulting i  | n the un  | deriving cause give                         | en in Part I.   |                | 23e. Did tobac                   | co use contribute t           | o the cause of death?                               |
| Records,            | uires<br>sign<br>ld be   | d by           |  |                                       |                  |           | , ,   |                 |                |                                  |                               | robably 4 Dunknown                                  |
| Ö                   | w require<br>been sign   | Completed      |  |                                       |                  |           |   |                 |                | 24a. Was an                      | 24h Woro a                    | utanu findinan available                            |
| Re                  | he lav   | Ę.             |  |                                       |                  |           |   |                 |                | autopsy                          | prior to                      | utopsy findings available<br>completion of cause of |
| Ø                   | n: T<br>ficate<br>or, pa   | ပိ             | 25. Was case referred to medical   |                                       |                  |           |   |                 |                | 1□ Yes 2□                        |                               | 2 🗆 No  |
| ⋚                   | Physician: The la<br>r this certificate has<br>ral director, page 2  | To Be          | avaminar?  | lospital:                             | t 2 ☐ ER/Ou      | test on   | 3 X DOA Othe                                |                 |                | neck only one)                   |                               |   |
| ō                   | Phy<br>er this   |                | 27. Manner of Death  | 28a. Date of Injury<br>(Month, Day    |                  | Time of   | 28c. Injury<br>Work                         | 4 🗆 1401        |                | Describe how i                   | e 6 Other (Speniury occurred  | ecity)  |
| <u></u>             | ath.<br>r: Afte<br>e fun   | atio           | 1 Natural 5 Pending 2 Accident investigation                                       | (Month, Day                           | rear) 1          | fnjury    |   | k?<br>Yes 2 ∭ N | No             |                                  |                               |   |
| Division of Vital   | ar dea   | tifica         | 3 ☐ Suicide 6 ☐ Could not be determined  | 28e. Place of fnius<br>building, etc. | y - At home, fa  | arm, stre | eet, factory, office                        |                 | 28f.           | Location (Stree                  | t and Number or A             | ural Route Number,                                  |
|                     | rs after all Direction   | Certification: |  | ballowing, etc.                       | (Specify)        |           |   |                 |                | City or Town, S                  | iate)                         |   |
|                     | To the Hospital or Attanding Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral   |                | 29a. Certifier 1 Certifying Phys   | sician: To the best of                | my knowledge     | e, death  | occurred at the timestigation, in my or     | ne, date and    | d place, and   | due to the caus                  | e(s) and manner a             | s stated.   |
|                     | the H<br>tha F<br>tha F  | Medicai        | one,   | and manner stat                       | ed.              |           |   |                 | in occurred a  |                                  |                               |   |
|                     | To To  | -              | 29b. Signature and title of certifier  | G ^                                   |                  |           | 29c. License                                |                 | _              | 29d.                             | Date signed (Mon              | th, Day, Year)                                      |
|                     | 0  |                | Karlleen W.  | Opin M                                | )                |           |   | 207             |                |                                  | 12/9/05                       |   |
|                     | 11   |                | 30. Name and address of person who co  | Hern MI                               | \                | (Type, I  | Win/h                                       | (De D           | Rain           | ncintl                           | Med.                          | 217/1   |
| # 0                 | Sta  | te             | 31. Date filed (Month, Day Year)   | 32. Regular                           |                  | 10        | 10111011                                    | LTVC            | IN W           | 130010K                          | 161                           | -1116   |
| 6                   | Pogietr  | -              | DEC 12   | ZUUD V                                | Page a           | X .       | Bearth 1                                    |                 |                |                                  |                               |   |

DHMH 17 Rev 1/2001

|                            |  |                | For<br>State<br>Registrar  | State of N  | Marylan        | d / Depa<br><i>Cei</i>           | artment et ificate          | of Healt<br>of Dea            | h and M<br>th                  |                                       | jiene                      | 305  | 41510   |
|----------------------------|--|----------------|--|---|----------------|----------------------------------|-----------------------------|-------------------------------|--------------------------------|---------------------------------------|----------------------------|--|---|
|                            |  |                | Decedent's Name (First, Middle, I  | Last)   |                |                                  |                             |                               |                                | 2. Date of Dea<br>Month               | th                         |  | 3. Time of Death                                |
|                            | Physici<br>/Medic  |                | Robert Dolbear   | e Lunsfor   | d              |                                  |                             |                               |                                | Decembe                               | r 6,                       | 200 <sup>Year</sup>                                  | 5:50 P™   |
|                            | Examin   |                | 4a. Facility Name (If not institution, g   |   | r)             |                                  |                             | own, or Locati                |                                |                                       |                            | unty of Death  |   |
|                            |  |                | 10 Rolling Knoll  5. Social Security Number 6  |   | Ana (In vrs    | last birthday)                   | If Under 1                  | ersbur                        | der 24 Hrs.                    | 8. Date of Birth                      |                            | tgomer   | hplace (State or Foreign                        |
|                            | Funeral Director   |                | 230-16-0223  | 1☐M 2□F   |                | 81 Yrs.                          |                             | Days Hou                      | irs Min.                       | Mar 7,                                | 1924                       | Co   | untry)  |
|                            | pc ,   |                | Usual Residence of Decedent  |   | 10.0           |                                  |                             |                               |                                |                                       |                            |  |   |
|                            | show   | č              | 10a. State 10b. County   |   |                | y, Town or Lo                    |                             |                               |                                |                                       |                            |  | 10d. Inside City Limits 1 Yes 2 No              |
|                            | 28a-f  | Director       | Maryland Montgon  10e. Street and Number   | nery  | Gait           | thersbu                          | 1 <b>r</b> g<br>10f. Zip C  | ode                           |                                |                                       | IOn Citizer                | n of What Co   |   |
|                            | 3a or  | Ö              | 10 Rolling Knol  | 1 Court   |                |                                  | 2087                        |                               |                                |                                       | USA                        | 10. 11.00  | unity.  |
|                            | deatl  | Funerai        | 11. Marital Status   | 12. Was Deceder   | nt Ever in U.  | .S. 13.                          | Was Deceder                 | nt of Hispanio                | Origin? (Specican, Puerto      | ecify Yes or No-                      | 14.                        | Race - Amer<br>Black, White                          |   |
| 36                         | hours after death with the Maryland<br>turel', or Itams 23s or 28s-f show<br>at Examinat must be motified at   | by Fu          | 1 Never Married 2 Married  | 1 XYes 2 If Yes, Give<br>Year or Dates                        | ] No           |                                  | 1 ☐ Yes 2                   |                               |                                | , , ,                                 | Sp                         | oecify: Whi  |   |
| 21215-0036                 | tural<br>tural   | ed b           | 3 ☐ Widowed 4 ☐ Divorced  15. Decedent's   |   | : WMTT         | 16a Dece                         | dent's Usual (              | Occupation                    |                                |                                       |                            | of Business/l  |   |
| 215                        | within 72<br>ene.<br>than "nai   | Completed      | (Specify only highest ) Elementary/Secondary (0-12)  |   | r 5+)          | (Give                            | kind of work<br>DO NOT use  | done during i                 | most of worki                  | ng                                    | TOD. INITO                 | 01 00311103321                                       | industry  |
| 21                         | filed with<br>Hygiene<br>other the   | Com            | Elomontary/Socialistry (5 12)  | 4   |                | Manage                           | ement                       |                               |                                |                                       | Compu                      | ter Co   | ompany  |
| Maryland                   | s 1 and 2 should be filed within 72 hours after death with the Marylar if Health and Mental Hygiene the Health and Mental Hygiene trems 23s or 28s-f show then 27 is marked other than "natural", or items 23s or 28s-f show other traumatic avant, the Medical Exertifier must be notified at | Be             | 17. Father's Name (First, Middle, La<br>Jesse Bascom Lui   | •   |                |                                  |                             |                               | other's Name                   | (First, Middle,                       | Maiden Su                  | mame)  |   |
| <u> </u>                   | 2 should be and Mental Is marked o   | ို             | 19a. Informant's Name/Relationship   |   |                | 10b Mailie                       | - Address /                 |                               |                                | I Route Numbe                         | . Cin T                    | Ct. to 3   | F- 0- 4-1                                       |
| <u>8</u>                   | od 2 s<br>lith an<br>27 is 1   |                | Isabelle I. Luns   |   |                | 1                                |                             |                               |                                | Gaithe                                |                            |  |   |
| altimore,                  | s 1 and 2<br>if Health<br>Item 27 I  |                | 20a. Method of Disposition   |   |                | Place of Dispo                   | sition (Name                | of                            |                                | ëfiber                                |                            | tion - City or 1                                     |   |
| Ē                          | Pages<br>nent of<br>ant: # It<br>ury or o  |                | 1 Durial 2 XCremation 3 4 Donation 5 Other (Spe  |   | (A) I .        | esapeal                          | ,                           |                               | 10,                            | 2005                                  | Belts                      | ville,   | Maryland  |
| Balt                       | permit. Page<br>Depertment of<br>Important: if<br>any Injury or<br>once.   |                | 21. Signature of Funeral Service Lie   | ensee   | 1 MO.          |                                  |                             |                               |                                | n Servi                               |                            |  |   |
|                            |  |                | 23a. Part1. Enter the disease, or co<br>shock, or heart failure. List or   | omplications that caus  | ed the death   |                                  |                             |                               |                                |                                       |                            | KSVIII   | e, MD 21029 Approximate Interval Between        |
| de.                        | Physician  |                | Immediate Cause (Final disease or condition  | ny one cause on each  | dem            | enti-                            |                             |                               |                                |                                       |                            |  | Onset and Death                                 |
| Ž.                         | /Medical<br>Examiner   |                | resulting in death)  | Due to (or a  | as a conseq    | 010110                           | <u></u>                     |                               |                                |                                       |                            |  | 1000  |
|                            | Examiner   | ۰.             | Sequentially list conditions,  | b. Due to fee   | as a cons      | A SERVICE PRO                    |                             |                               |                                |                                       |                            |  |   |
|                            | ted<br>nsit  | nine           | Sequentially list conditions, any, leading to make the cause. Enter Underlying Cause (Disease or injury  | Due to for s  | as a consequ   | uando orj:                       |                             |                               |                                |                                       |                            |  |   |
| Ć,                         | execu<br>n and<br>ial-tra  | Examiner       | that initiated events<br>resulting in death) Last  | c<br>Due to (or a   | as a conseq    | uence of):                       |                             |                               |                                |                                       |                            |  |   |
| 8760,                      | cate be executed<br>physicien and<br>the burial-transit  | dical          |  | d   |                |                                  |                             |                               |                                |                                       |                            |  |   |
| 9                          |  | Med            | IF FEMALE:   |   |                |                                  |                             |                               |                                |                                       |                            |  |   |
| . Box                      | that the death certiff<br>ed by the ettending<br>detached for use as   | Physician/Me   | 23b. Was decedent pregnant in the past 12 months?  | 23c. If yes, outcom<br>1☐Live birth<br>4☐Pregnant             | 2 ☐Feta        | I death 3                        | Ectopic preg                |                               |                                |                                       | 23d                        | <ol> <li>Date of delifined</li> <li>Month</li> </ol> | very<br>Day Year                                |
| o.                         | the de   | ysic           | 1 □ Yes 2 □ No<br>9 □ Unknown  | 9□ Unknown  |                | eain 5                           | Other (spec                 | :#y)                          |                                |                                       |                            |  | ·   |
| ۵.                         | res that<br>igned b<br>be deta   | by Pt          | Part II. Other significant condition   | s contributing to death                                       | but not res    | ulting in the u                  | nderlying cau               | ise given in P                | art I.                         | 23e. Did to                           | bacco use                  | contribute to  | the cause of death?                             |
| ğ                          | w require<br>been sig<br>should b  |                |  |   |                |                                  |                             |                               |                                | 1 □ Y                                 | es 2□N                     | lo 3□Pro   | obably 4 Donknown                               |
| Division of Vital Records, | et es es   | Completed      |  |   |                |                                  |                             |                               |                                | 24a. Was a                            | in 2                       | 4b. Were auf   | topsy findings available completion of cause of |
| <u>~</u>                   |  | Con            |  |   |                |                                  |                             |                               |                                | perfor                                | med2<br>2 No               | death?   | 2 🗆 No  |
| <u> </u>                   | ysician:<br>is certific<br>director,   | o Be           | 25. Was case referred to medical examiner?   | Hospital:   |                | <b>5</b> D/0                     |                             | Other                         |                                | (Check only or                        |                            |  |   |
| ō                          | Attending Physician: r death. sctor: After this certific by the funeral director,  | <del> </del>   | 1 ☐ Yes 2 ☐ No  27. Manper of Death  | 28a. Date of Ir   | njury          | ER/Outpatier<br>28b. Time of     |                             | : Injury at                   |                                | me 5 Resid<br>28d. Describe h         |                            | Other (Spec  | eify)   |
| <u>o</u>                   | nding<br>ath.<br>r: Afte   | atio           | 1 ☐Natural 5 ☐ Pending<br>2 ☐ Accident investiga   |   | Day Year)      | Injury                           | м                           | Work?<br>1 ∐ Yes 2            | 2 🗆 No                         |                                       |                            |  |   |
| <u> </u>                   |  | Certification: | 3 ☐ Suicide 6 ☐ Could no<br>4 ☐ Homicide determine   | ed 289. Place of I  | Injury - At ho | ome, farm, str                   | eet, factory, o             | office                        |                                | 28f. Location (S<br>City or Tow       | treet and N                | lumber or Ru   | ral Route Number,                               |
|                            | urs of<br>urs of<br>sref D   |                |  |   |                |                                  |                             |                               |                                |                                       |                            |  |   |
|                            | To the Hospital or Attenwithin 24 hours effer deat To the Funerel Director: completely filled in by the  | Medical        | 29a. Certifier  (Check only one)  1 ✓ Certifying 2 ☐ Medical Ex  | Physician: To the best<br>caminer: On the basis<br>and manner | of examina     | wledge, death<br>ition and/or in | occurred at vestigation, in | the time, date<br>my opinion, | e and place, a<br>death occurr | and due to the c<br>ed at the time, c | ause(s) and<br>ate and pla | d manner as<br>ace, and due                          | stated.<br>to the cause(s)                      |
|                            | To the within 2 To the complet   | Me             | 29b. Signature and it of certifier   |   |                |                                  | 29c. t                      | License numb                  | oer /                          | . 2                                   | 9d. Date s                 | igned (Month   | Dev Year)                                       |
| -                          | 16   |                | 1/1/   | John.   | 8              |                                  | U                           | . 70                          | 148                            |                                       | Vec                        | ember  | 7,200   |
| 14                         | 2  |                | 30. Name and address of person when the state of the stat | no completed cause of   | f death (Item  | 23a) (Type.                      | Print)<br>USSE              | Avo                           | e, 6                           | Saithers                              | pure                       | , m  | )d.   |
|                            | Sta<br>Registi   |                | 31. Date filed (Month, Day, Year)  | 100   | strar's Signa  | ature                            | lagall :                    | ,                             |                                |                                       |                            |  |   |
|                            | negisti  | aı             | DEC 1 2  | 7003  |                | N. 10                            | The state of the state of   |                               |                                |                                       |                            |  |   |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) () 5 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Month **Physician** M=2PHY DONUA 2005 DECEMBERIL /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner oppor chesadeare medical center BEZANL HARCOND 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day Year) 63 Yrs. Months Days Hours Min. 6/10/1942 5. Social Security Number 9. Birthplace (State or Foreign Funeral 1 M 200 Pennsylvania Director 557-56-9034 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 27 is marked other than "natural", or items 23a or 28a-f ahow traumatic avent, the Medical Examinat must be notified at PA Delta York 1 ☐ Yes 2 → No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 329 Main Street 17314 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates: land 21215-0036 1 ☐ Yes 🎾 No White Specify: '3 Kg Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Retail Sales Store Owner 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 2 should be and Mental I Verna Smith Albert Yockey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 17314 Health Item 27 329 Main Street, Delta, PA Tina Black/Daughter Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other p 20a. Method of Disposition Date 20c. Location - City or Town, State Pages nent of h 1 ☐ Burial 2 ▼ Cremation 3 ☐ Removal from State
1 ☐ Donation 5 ☐ Other (Specify) Evans Fagle Crematory Leola, PA 12/18/2005 21. Signature of Funeral Service Licensee Harkins Funeral Home, Inc., 600 Main St., Delta, PA 17314 234. P n1 from the discusse, or coordications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List they one cause on each line. Approximate mediate Cause (Final Onset and Death **Physician** disease or condition resulting in death) HASLUD /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate the Enter Union Cause (Disease or injury that initiated events Due to (or as a consequence of): been signed by the attending physician and should be detached for use as the burial-transit resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ HEANT FAILURE 3 Probably 4 □Unknown obstructure pul morary 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an autopsy performed? Murphy, Donna Mikrel Velue replacement 1 Yes 2 4 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 5 Pending investigation 1 ZNatural To the Hospital or Attendir within 24 hours after death.
To the Funeral Director: At completely filled in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 🗌 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) M.03 DETEMBEN 16 2005 21809

State Registrar

0

31. Date filed (Month, Day, Year)

PNASHO

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MO

2336 YOUK

DHMH 17 Rev 1/2001

MB0044888

NO IIMONIUMINUS 2109

|             |  |  |                     | for<br>State<br>Registrer   | State of   | Maryla              | nd / Depa<br><i>Cei</i>                   | artment<br>rtificate                            | of He   | ealth and<br><i>eath</i>        | d Mental H                                 | ygiene<br>Reg. No.      |                            |                           | 1612   |
|-------------|--|--|---------------------|---|--|---------------------|---|---|---|---------------------------------|--|-------------------------|----------------------------|---------------------------|--|
| _           |  | Physici  |                     | 1. Decedent's Name (First, Middle, La<br>EVELYN LOUISE  | st)<br>MCGOLER]  | ICK                 |   |   |   |                                 | 2. Date of D<br>Month<br>Decem             | eath                    | 12, 20°                    | ენ                        | 3. Time of Death 2:40 am <sup>M</sup>              |
|             |  | /Medic<br>Examin   |                     | 4a. Facility Name (If not institution, giv<br>REEDERS MEMORIAL  | e street and num                                       |                     |   | 4b. City, T                                     |   | ocation of De                   | eath                                       |                         | County of De               | ath                       | NGTON  |
|             |  | Funeral<br>Director  |                     | 219-20-3933   | ex<br>□M 2AF   | 7. Age (In yr: 79   | s. last birthday)<br>Yrs.                 | If Under 1<br>Months                            | Year<br>Days                                  | If Under 24 H<br>Hours W        | lin. (Month, D                             | av. Year)               | 26 9. E                    | Birthpla<br>Countr<br>MAR | ice (State or Foreign<br>y)<br>XYLAND              |
|             | death with the Maryland  | f show   | tor                 | Usual Residence of Decedent           10a. State         10b. County           MARYLAND         WASHT   | NCTON  | 10c. C              | City, Town or Lo                          |   | KEEN  | YSVILL                          |  |                         |                            | 100                       | d. Inside City Limits 1 ☐ Yes 2 🛣 No               |
| 4           | with the   | a or 28a   | Direc               | 10e. Street and Number 4407 TREGO ROAD  | NOTON  |                     |   | 10f. Zip 0                                      | Code  | 1756                            | ظا   | 10g. Citi               | zen of What                | Countr                    | •  |
| velu        | 36<br>s after death  | , or items 23  | by Funeral Director | 11. Marital Status  1 □ Never Married 2 ▼ Married  3 □ Widowed 4 □ Divorced   | 12. Was Deced<br>Armed Ford<br>1 Tes 2<br>If Yes, Give | ces?<br>2 XNo       |   | Was Decede<br>f Yes, specif                     | ent of His<br>fy Cuban,                       |                                 | (Specify Yes or Nuerto Rican, etc.)        | 10-                     | 14. Race - Ar<br>Black, Wi | nerica                    | n Indian,  |
| البلا       | <b>215-003</b> Ithin 72 hours  | e.<br>an "naturel<br>Medical Er  | Completed b         | 15. Decedent's E. (Specify only highest grade) Elementary/Secondary (0-12)  | Year or Da ducation ide completed)  College (1-        |                     | (Give                                     | dent's Usual<br>kind of work<br>DO NOT use      | done du                                       | ion<br>ring most of             | working                                    | 16b. Ki                 | nd of Busines              | VHI']<br>ss/Indu          |  |
| 11cK        | and 21   | antal Hygien<br>ted other th   | Be                  | 9 17. Father's Name (First, Middle, Last, ROY HOLMES  | ,  | ·                   |   | HOM   | EMAK]   |                                 | Name (First, Middl<br>COYLE                | e, Maiden               | OWN<br>Sumame)             | ГН                        | IOME   |
| Name McGole | Baltimore, Maryland  | Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "naturel", or items 23a or 28a-f shot any injury or other treumatic event, I've Medical Exercitor must be notified at 2008.  | То                  | 19a. Informant's Name/Relationship ( BRENDA J. HASSIN 20a. Method of Disposition 1 Aburial 2 Cremation 3 4 Donation 5 Other (Specification 2). Signature of Funeral Service Licentees   | GER, DAU   | 20b.                | 1807 Place of Dispondentery, crer AIRVIEW | BRIGI<br>sition (Name<br>natory or oth<br>CEME) | HTWO<br>e of<br>ner place)<br>TERY<br>Address | OD DRI                          | Pural Route Num.  VE, HAGEI  Date  14/2005 | RSTOW<br>20c. Lo<br>KEE | N, MAR cation - City of    | YLA<br>or Tow<br>LE,      | ND 21740<br>n, State<br>MARYLAND                   |
| Na          | 8760, sate be executed mind and sate by executed mind and sate by executed mind and sate by the sate of the sate o | hysician and prize transit the prize transit t | dical Examiner      | 23a. Hart1. Enter the disease, or composed when the cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | a. Multa Due to (c                                     | place or as a conse | equence of):                              | er the mode                                     |   | such as card                    | BOONSBO                                    |                         | MARYLA                     | Į.                        | 21713 Approximate Interval Between Onset and Death |
|             | P.O. Box 6   | y the attending p  | Physician/Me        | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown   |  | th 2 Fe             | tal death 3                               | Ectopic pred<br>Other (spec                     |   |                                 |  | 2                       | 23d. Date of d<br>Month    |                           | ay Year  |
|             | rds, P.  | been signed by the a<br>should be detached f   | by                  | Part II. Other significant conditions of  | ontributing to dea                                     | ath but not re      | sulting in the u                          | nderlying cau                                   | use given                                     | in Part I.                      |  |                         | /                          |                           | cause of death?                                    |
|             | I Reco   | ath.<br>r: After this certificate has been<br>e funeral director, page 2 shoul   | Completed           |   |  | <del></del>         |   |   |   |                                 | 24a. Wa:<br>auto<br>perf<br>1 □ Yes        |                         | 24b. Were prior to death?  |                           | y findings available<br>detion of cause of         |
|             | /ita   | ertific<br>sctor,  | Be                  | 25. Was case referred to medical examiner?  | 11   |                     |   |   |   | 26. Place of E                  | Death (Check only                          | one)                    |                            |                           |  |
|             | of Johnson   | this o   | 으                   | 1 Yes 2 No  |  |                     | ER/Outpatien                              |   |   | 4 Nursing                       |  |                         | Other (Sp                  | ecify)                    |  |
|             | Division of Vital Records, P.O. Box 6  | within 24 hours after death.  To the Funerel Director: After completely filled in by the funer.  | Certification:      | 27. Manner of Death   Natural   5   Pending investigation   3   Suicide   4   Homicide   Homicide   Homicide   Homicide   Homicide   Pending investigation  |  |                     | 28b. Time of<br>Injury<br>home, farm, str | М   |   | s 2□No                          | 28f. Location<br>City or To                |                         | d Number or i              | Rural F                   | Route Number,                                      |
|             | he Hospite   | within 24 hours after deatl<br>To the Funerel Director:<br>completely filled in by the   | Medical C           | 29a. Certifier  (Check only one)  12 Certifying Ph 2 Medicel Exert  | ysicien: To the base                                   | sis of examin       | owledge, death<br>action and/or inv       | occurred at<br>restigation, in                  | t the time,<br>n my opin                      | , date and pla<br>ion, death oc | ace, and due to the<br>courred at the time | cause(s),<br>date and   | and manner a               | as state                  | ed.  |
| •           | Tot  | withi<br>To t  | Σ                   | 29b. Signature and title of certifier  Affine   | t mo   |                     |   |   | License r                                     |                                 |  |                         | signed (Mor                |                           | y, Year)   |
|             | 15H-   | 10   |                     | 30. Name and address of person who Dr. Robert Gueden  |  |                     |   |   | ro,   | MD 21                           | 713 301                                    |                         |                            |                           |  |
|             |  | Sta<br>Registr   |                     | 31. Date filed (Month, Day, Year)   |  | gistrar's Sigr      |   | artes   |   |                                 |  |                         |                            |                           |  |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiege 1 0 5

|             |  |                  | 1 - For<br>State<br>Registrar   | State of Ma  | aryland /                    |                        | artment of F<br><i>tificate of</i> .                             |  | Mental Hygi<br>Re                          | IEME                            | 5                         | 1613   |
|-------------|--|------------------|---|--|------------------------------|------------------------|--|--|--|---------------------------------|---------------------------|--|
|             | Physici  | 20               | 1. Decedent's Name (First, Middle, Las  |  |                              |                        |  |  | 2. Date of Death<br>Month                  |                                 | Year                      | 3. Time of Death                                   |
|             | /Medic   |                  | MILDRED   | ANN  | MACK                         |                        |  |  | DECEMBE                                    | R 7 20                          | 05                        | 1.10p M  |
|             | Funeral  | er               | 4a. Facility Name (If not institution, give  Frederick Memori  5. Social Security Number  6. Se           | al Hospita<br>x 7. Age   | (In yrs. last b              | oirthday)<br>Yrs.      | 4b. City, Town, o  Frederic If Under 1 Year Months Days          | k If Under 24 Hrs. Hours Min.              | 8. Date of Birth                           | 4c. County Frede                | 9. Birthp                 | ace (State or Foreign                              |
|             | Director   |                  | 217-34-9160 Usual Residence of Decedent   |  | 64                           | 113.                   |  |  | Dec. 14,                                   | 1940                            | Mary                      | land   |
|             | rylanc<br>how  |                  | 10a. State 10b. County  |  | 10c. City, To                | wn or Lo               | cation   |  |  |                                 | 11                        | 0d. Inside City Limits                             |
|             | 8a-f s   | cto              | Maryland Frederic   | k  | Fre                          | deri                   |  |  | -,   |                                 |                           | 1 ☐ Yes 2 ☑ No                                     |
|             | with the a or 2  | Funeral Director | 10e. Street and Number  |  |                              |                        | 10f. Zip Code  |  | 10   | g. Citizen of                   | What Coun                 | try?   |
|             | ns 23  | era              | 4501 Cap Stine R  | 12. Was Decedent 8   | ver in U.S.                  | 13. \                  | 217 Was Decedent of H  |  | pecify Yes or No-                          | Unite<br>14. Bac                | d Sta                     |  |
| 036         | ours after or iter   |                  | 1 ☐ Never Married 2 ☑ Married<br>3 ☐ Widowed 4 ☐ Divorced   | Armed Forces?  1 ☐ Yes 2 ☑ N  If Yes, Give Year or Dates:            |                              |                        | Vas Decedent of H<br>f Yes, specify Cuba<br>I□Yes 2⊠ No          | Specify:                                   | o Rican, etc.)                             | Bla                             | ck, White, e<br>y: Whi    | etc.   |
| 21215-0036  | permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23e or 28a-f show any injury or other traumatic event, the Medical Evanirer must be notified at once.  | Completed by     | 15. Decedent's Ed<br>(Specify only highest grad<br>Elementary/Secondary (0-12)                            | ucation<br>de completed)<br>College (1-4or 5                         | +)                           | (Give<br>lite. L       | lent's Usual Occup<br>kind of work done of<br>OO NOT use retired | durina most of won                         | king                                       | 6b. Kind of B                   |                           | lustry   |
|             | filed v<br>Hygie<br>other i  |                  | 17. Father's Name (First, Middle, Last)   |  |                              | Home                   | maker  | 18. Mother's Nam                           | ne (First, Middle, M                       | Own H                           |                           |  |
| <u>la</u> n | Aental<br>Aental<br>rked c   | To Be            | George Engle  |  |                              |                        |  | Blanch                                     | ne Edward                                  | s                               | ,                         |  |
| Maryland    | 2 shot<br>and A<br>is ma   |                  | 19a. Informant's Name/Relationship (T   |  |                              | b. Mailin              | g Address (Street  | and Number or Ru                           | ral Route Number,                          | City or Town,                   | State, Zip                | Code)  |
|             | f and<br>fealth<br>sm 27<br>sher tr  |                  | Ferdinand J. Mack   | / Husband  |                              |                        | Cap Stin   |  | Frederick                                  |                                 |                           |  |
| Baltimore,  | ages<br>nt of h<br>t: If Ite   |                  | 20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3 ☐ I  |  | cemete                       | ery, cren              | natory or other place  | Decei                                      | mber                                       | Oc. Location                    | ,                         |  |
| 턡           | artme<br>ortani<br>injury  | i                | <ul><li>4 □ Donation 5 □ Other (Specify,</li><li>21. Signa ure of Fundal Service Licens</li></ul>         |  | Mt. C                        |                        | et Cemete  |  | 2005 F                                     | rederi                          | ck, M                     | aryland  |
| ä           | Depar<br>Impo<br>any ir  |                  | 1 7/20  | to   |                              | 16                     | 21 Opossi  | umtown Pi                                  | auffer Fu<br>ke Fred                       | neral<br>erick,                 | Homes<br>Mary             | , P.A.<br>land 21702                               |
| į           | Physician  |                  | 23a. Part1. Enter the disease, or comp<br>shock, or heart failure. List only of<br>Immediate Cause (Final | lications that caused<br>ne cause on each lin                        | the death. Do                | not ente               |  |  | or respiratory arre                        | st,                             |                           | Approximate<br>Interval Between<br>Onset and Death |
|             | /Medical<br>Examiner   |                  | disease or condition resulting in death)  | a. Due to (or as a   | consequence                  | of):                   | Can  | 1 Cer                                      |  |                                 |                           | 2 /  |
|             | LAGIIIIICI   | 20               | Sequentially list conditions, if any, leading to miniculate cause. Enter Underlying                       | b. Qualo (or as s  | consequence                  | offe                   |  |  |  |                                 |                           |  |
|             | uted<br>d<br>ansit   | Examiner         | cause. Enter Undertying Cause (Disease or injury that initiated events                                    |  |                              |                        |  |  |  |                                 |                           |  |
| oʻ          | e exectan an a  | Еха              | resulting in death) Last  | Due to (or as a  | consequence                  | of):                   |  |  |  |                                 |                           |  |
| 68760,      | rificate be executed g physician and as the burial-transit   | edical           |   | d  |                              |                        |  |  |  |                                 |                           |  |
| .O. Box 6   | The law requires that the death certificate has been signed by the attending page 2 should be detached for use as  | by Physician/Me  | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown                     | 23c. If yes, outcome of 1 □ Live birth 1 4 □ Pregnant at 9 □ Unknown | 2 Fetal deat                 |                        | Ectopic pregnancy<br>Other (specify)                             |  |  | 23d. Dai<br>Mo                  | te of deliver             | y<br>Day Year                                      |
| S, P.       | that the post of t | y Ph             | Part II. Other significant conditions co  | ntributing to death bu   | t not resulting              | in the un              | derlying cause give  | en in Part I.                              | 23e. Did toba                              | icco use cont                   | ribute to the             | cause of death?                                    |
| rds         | w require:<br>been sig<br>should by  |                  |   |  |                              |                        |  |  | 1 ☐ Yes                                    | 5 No                            | 3 🗌 Proba                 | ibly 4 □Unknown                                    |
| Record      | ysician: The law re<br>is certificate has be<br>director, page 2 shr   | Completed        |   |  |                              |                        |  |  | 24a. Was an autopsy perform                | ed?                             | prior to com<br>death?    | sy findings available ipletion of cause of         |
| Vital       |  | Bec              | 25. Was case referred to medical examiner?  |  |                              |                        |  | 26. Place of Deat                          | 1 ☐ Yes 2)<br>th (Check only one           |                                 | 163                       | 2 No   |
| of<br>O     | Physician:<br>this certific<br>ral director,   | 2                | 1 ☐ Yes 2 No  | Hospital: 1 Inpatier   | -                            |                        |  | 4   Nursing Ho                             | ome 5 Residen                              |                                 |                           |  |
| On          | ding I<br>h.<br>After<br>funer   | tlon             | 27. Manner of Death  1 Natural 5 Pending 2 Accident investigation   | 28a. Date of Injury<br>(Month, Day                                   |                              | Time of<br>Injury      | 28c. Injury<br>Work  | rat<br>c?<br>Yes 2 □ No                    | 28d. Describe how                          | injury occurr                   | ed                        |  |
| Division of | To the Hospitel or Attending Ph<br>within 24 hours after death.<br>To the Funeral Director: After th<br>completely filled in by the funeral  | Certification:   | 2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined                                   | 28e. Place of Inju   | ry - At home, f<br>(Specify) | arm, stre              |  | .03 2                                      | 28f. Location (Stre<br>City or Town,       | et and Numb<br>State)           | er or Rural               | Route Number,                                      |
|             | To the Hospitel or within 24 hours after to the Funeral Direction completely filled in h   | edical C         | 29a. Certifier 12 Certifying Phy (Check only one)   | sician: To the best oner: On the basis of and manner state           | examination ai               | je, death<br>nd/or inv | occurred at the timestigation, in my op                          | ne, date and place,<br>pinion, death occur | and due to the cau<br>red at the time, dat | ise(s) and ma<br>e and place, a | nner as sta<br>and due to | ted.<br>the cause(s)                               |
|             | To th<br>within<br>To th<br>comp   | Me               | 29b. Signature and title of certifie  | 26   | MD                           |                        | 29c. License   | number                                     | 290  | d. Date signed                  | (Month, D                 | lay, Year)   |
|             | 5  |                  | 100   | 411  | 5                            |                        | D  | 4818                                       | 4 1  | 2171                            | 05                        |  |
|             | 0  |                  | 1,01111   | nder, MI   | 50                           | (Type, F               | Print) The str   | eet Fred                                   | brak, N                                    | 17) 3                           | 2170                      | )  |
|             | Sta<br>Registr   |                  | 31. Date filed (Month, Day, Year)   | 1005 32. Pictistra   | r's Signature                | 4                      | books  |  |  |                                 |                           |  |

|   |   |                  | For<br>State<br>Registrar  |   | arylan               |                                  | artment of H<br>tificate of L                                     |                                      | ınd M           |  | ene() ()          | 5                         | 41614  |
|---|---|------------------|--|---|----------------------|----------------------------------|---|--------------------------------------|-----------------|--|-------------------|---------------------------|--|
| ı   | Physicia  |                  | 1. Decedent's Name (First, Middle, Las<br>Sherry Rae   | Maillet   |                      |                                  |   |                                      |                 | 2. Date of Death<br>Month<br>December  |                   | 2005                      | 3. Time of Death 10:20P M                                    |
|   | /Medic<br>Examin  | _                | 4a. Fecility Name (If not institution, give  |   |                      |                                  | 4b. City, Town, or  | Location of                          |                 | December                               | 4c. County        |                           | 10.201 11  |
|   | LAGITITI  | C1               | 3220 Sidetracked   |   |                      |                                  | New W   |                                      |                 |  | Ca                | arrol                     | 1  |
|   | Funeral<br>Director   | 100              | 5. Social Security Number 6. S 312-46-8449 1 Usual Residence of Decedent   | ex 7. Ag<br>□ M 2 <b>⊠</b> F  | ge (In yrs.<br>64    | last birthday)<br>Yrs.           | If Under 1 Year<br>Months Days                                    | If Under 2<br>Hours                  | 24 Hrs.<br>Min. | 8. Date of Birth (Month, Day, July 27, | <sup>Y</sup> 1941 | 9. Birthp<br>Cour<br>Cana | plage (State or Screige i<br>nin) 1004 a or Screige i<br>Ida |
|   | yland   |                  | 10a. State 10b. County   |   | 10c. Cit             | y, Town or Lo                    | cation  |                                      |                 |  |                   | 1                         | 10d. Inside City Limits                                      |
|   | e Mariat  | cto              | Maryland Carro   | 11  |                      |                                  | New Win   | dsor                                 |                 |  |                   |                           | 1 ☐ Yes 2 💆 No   |
|   | vith th   | Dire             | 10e. Street and Number   |   |                      |                                  | 10f. Zip Code   |                                      |                 | 10                                     | g. Citizen of     |                           | ntry?  |
|   | eath v  | eral             | 3220 Sidetrack   | ed Dr. 12. Was Decedent   | Ever in II           | S 12 1                           |   | 776                                  | nin? (Sne       | city Vac or No-                        |                   | .S.A.                     | an Indian  |
| 9   | within 72 hours after death with the Maryland<br>ene.<br>then "natural", or items 23e or 28e-f show<br>the Modical Extralight", ust be notified at  | Funeral Director | 1 Never Married 2 Married  | Armed Forces? 1 ☐ Yes 2X  | ?                    |                                  | Was Decedent of Hill<br>f Yes, specify Cubar                      |                                      | , Puerto I      | Rican, etc.)                           | Bla               | ck, White,                |  |
| 8   | ural, c   | d by             | 3 Widowed 4 Divorced   | If Yes, Give<br>Year or Dates:  |                      |                                  | 1 ☐ Yes 2X No   | Specify:                             |                 |  | Specif            | y: W                      | hite   |
| 21215-0036  | n 72 h<br>"natu   | Completed        | 15. Decedent's Ed<br>(Specify only highest gra   | de completed)   |                      | 16a. Deced                       | dent's Usual Occupa<br>kind of work done d<br>DO NOT use retired, | atio <b>n</b><br>fu <i>ring most</i> | of working      | ng                                     | 6b. Kind of B     | usiness/In                | dustry   |
| 212   | s withi<br>jene.<br>r than  | omp              | Elementary/Secondary (0-12)  | College (1-4or  | 5+)                  | ł                                | homemaker   |                                      |                 |  | 01                | wn ho                     | me   |
| nd  | al Hyg  |                  | 17. Father's Name (First, Middle, Last)  |   |                      |                                  |   |                                      |                 | (First, Middle, N                      | faiden Sumar      | ne)                       |  |
| yla   | ould to Ment  | To Be            | Arthur Roze  |   |                      |                                  |   |                                      |                 | 0rgan                                  |                   |                           |  |
| Maryland  | d 2 sh<br>th and<br>th sun<br>traum   |                  | 19a. Informant's Name/Relationship ( Wilfrid Maillet/  |   |                      |                                  | ng Address (Street a<br>Sidetrac                                  |                                      |                 |  |                   |                           | ,  |
|   | is 1 and 2<br>of Health a<br>item 27 is<br>other trai   |                  | 20a. Method of Disposition   |   |                      | lace of Dispo                    | sition (Name of natory or other place                             | 1                                    |                 |  | Oc. Location      |                           |  |
| E   | Page:   |                  | 1 ☐ Burial 2 ☐ Cremation 3 ☐  `4 ☐ Donation 5 ☐ Other (Specify   |   | 1                    |                                  | y Cremati   |                                      | 2/8/            | 2005                                   | Sykes             | ville                     | , MD   |
| Baltimore,  | permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23e or 28e-f show any injury or other traumatic event, the Modical Extrapriate is used by notified at 900. |                  | 21. Signature of Funeral Service Licen   | O. Har  | Ble                  |                                  | Name and Addres   |                                      |                 | tzler F                                |                   |                           |  |
|   |   |                  | 23a. Part1. Enter the disease, or com<br>shock, or heart failure. List only  | plications that cause<br>one cause on each I                            | d the death          | h. Do not ent                    | er the mode of dying  | g, such as                           | cardiac o       | r respiratory arre                     | st,               |                           | Approximate<br>Interval Between                              |
|   | Physician<br>/Medical   |                  | Immediate Cause (Final disease or condition resulting in death)  | a Myo   | CAR                  | DIAL                             | - 1SCI  | nem                                  | ici             |  |                   |                           | Poset and Death  |
| 90,   | Examiner  | i Examiner       | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Due to (or as  | a conseq             | uence of): uence of): uence of): | Rectu   | 1 ca                                 | u Ce            |  |                   |                           | month  |
| 8760,   | cate b<br>physic<br>the b   | edicai           | •  | d   |                      |                                  |   |                                      |                 |  |                   |                           |  |
| P.O. Box 6  | that the death certificate be executed ned by the attending physician and detached for use as the burial-transit  | Physician/Me     | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2  Mo 9  Unknown   | 23c. If yes, outcome<br>1 □ Live birth<br>4 □ Pregnant a<br>9 □ Unknown | 2 Feta               | Ideath 3                         | Ectopic pregnancy Other (specify)                                 |                                      |                 |  |                   | ite of delive             | ery<br>Day Year  |
|   | that<br>ed b<br>deta  | by               | Part II. Other significant conditions of   |   | out not res          | ulting in the u                  | nderlying cause give  | en in Part I.                        |                 |  | acco use con      | tribute to th             | ne cause of death?   |
| CO  | law requires<br>as been sign<br>2 should be   | Completed        |  |   |                      |                                  |   |                                      |                 | 24a. Was ar                            |                   | Were auto                 | psy findings available                                       |
| Re  | e + e   | mo               |  |   |                      |                                  |   |                                      |                 | autopsy<br>perform<br>1 Yes 2          | ied?              | death?                    | mpletion of cause of<br>2□ No                                |
| /ita  | i <b>ician</b> : Th<br>certificate<br>rector, pag   | ВеС              | 25. Was case referred to medical examiner?   |   |                      |                                  |   | 26. Place                            | of Death        | (Check only one                        |                   |                           |  |
| Se   |   |                  |  |   |                      |                                  |   |                                      |                 |  |                   | y)                        |  |
| 27. Manner of Death 1 ST Natural 2 Accident 3 Suicide 4 Homicide 28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 1 Yes 2 No 28c. Injury at Work? Injury M 1 Yes 2 No 28c. Injury at Work? 1 Yes 2 No 28c. Injury at Work? 28d. Describe how injury occurred |   |                  |  |   |                      |                                  |   |                                      |                 | oer or Rura                            | il Route Number,  |                           |  |
|   | To the Hospital or Attent within 24 hours efter deall To the Funeral Director: completely filled in by the  | edical C         | 29a. Certifier (Check only one)  Certifying Ph   | nysician: To the best<br>niner: On the basis of<br>and manners          | of examina<br>tated. | ition and/or in                  | vestigation, in my op   | inion, deat                          | th occurre      | ed at the time, da                     | te and place,     | and due to                | the cause(s)   |
|   | N   | W                | 29b. Signature and title of certifier  A - Z - 1   | HEGAZ   | į                    |                                  | 29c. License<br>0 4<br>Print) John                                | number<br>L+ 18                      | 54              | 29                                     | d. Date signe     | d (Month,                 | Day, Year)   |
|   | Mile  |                  | 30. Name and address of person who A - Z - I+EGAZI   | MD 48   | death (Item          | n 23a) (Туре,<br>Иошо            | Print) John.  | jon                                  | Dr,             | Frede                                  | ruck 1            | 102                       | 21702  |
|   | Sta<br>Registi  |                  | 31. Date filed (Month, Day, Year) DEC 0 8  | 2005 32. Region   |                      |                                  |   |                                      |                 |  |                   |                           |  |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend Item#5 per FH C851 1/5/06 CC

1- State of Maryland Department of Health and Mental Hygiene 1 5

Reg. No. 1- State of Death Registrar 25 26 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month Brownie Lee Moses Dec. 2005 8:43 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Silver Spring, Md.
If Under 1 Year If Under 24 Hrs. 8 Date Holy Cross Hospital Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 578-26-4054 1 M 2 XF 94 Yrs. Director May 11,1911South Carolina Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits in then "natural", or items 23s or 28s-f show the Medical Examiner must be notified at Director D.C. Washington 1 X Yes 2 □ No the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 831 Whittier P1N.W. 20012 United States deeth Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 72 hours after 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐XNo þ Specify: Black 3 X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) ink Unil unil 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Jerry Giles Annie Crockett 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 i Shirlev A. Ross 502 Valley Park Ct. Seat Pleasant, Md.20743 20b. Place of Disposition (Name of cometery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State ō <u>=</u> ty⊐Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) permit. Page Depertment of Important: if eny injury or pnce. Maryland National Dec. 17, 2005 Laurel, Md. 21. Signature of Funeral Service Licensee, 22. Name and Address of Facility Latney's Funeral Home, Inc. lleums 3831 Georgia Ave. N.W. Wash.,DC 20011 23a. Part1. Ener the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Cardiomyopathy /Medical Due to (or as a consequence of): Examiner Coronary Artery Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (c) as a consequence of). Examine requires that the death certificate be executed attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown s been signed by to should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ガクタッチ/ Division of Vital Records, Š Renal Failure 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Winknown Completed Gangrene Left Foot 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Wasan certificate 1 Yes 2 🖳 No 25. Was case referred to medical examiner? 26. Place of Death Check only one Hospital: 1 Inpatient 2 ER/Outpatient Other 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 3 DOA After thi 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification; 5 Pending investigation 1 XNatural death. 1 ☐ Yes 2 ☐ No 2 Accident Director: filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours efter To the Funeral Dire 4 Homicide ō Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mapner stated. 29a, Certifier 29b. Signature and fitte of certified 29c. License number 29d. Date signed (Month, Day, Year) D21153 30. Na and address of person who completed cause of death (Item 23a) (Type, Print) 1500 Forest Glen Road; Silver Spring, MD Gerry/Rubin, 31. Date filed (Month, Day, Year)
DEC 2 3 2005 32. Registrar's Signature

DHMH 17 Rev 1/2001

State Registrar

Physic /Medi Exami

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit 5x1 31. Date filed (Month, Day, Year)

DEC 2 3 2005

32. Registrar's Signature State Registrar DHMH 17 Rev 1/2001 ORIGINAL

|                        | 1- State of Maryland / Registrar   | -                      | artment of H   |   |  | giene 05                                 | 41616   |
|------------------------|--|------------------------|--|---|--|--|---|
|                        | Decedent's Name (First, Middle, Last)  |                        |  |   | 2. Date of De                                | ath                                      | 3. Time of Death  |
| an                     | LANCE NORMAN PERRY   |                        |  |   | Decembe                                      |  | 05 2:55A M  |
| cal<br>1er             | 4a. Facility Name (If not institution, give street and number)   |                        | 4b. City, Town, or   | Location of                             |  | 4c. County of                            | , 2, 3, 1   |
|                        | Civista Medical Center   |                        | La Pla   | ata                                     |  | Charle                                   | es  |
|                        | 5. Social Security Number 6. Sex 7. Age (In yrs. last  | birthday)              | If Under 1 Year<br>Months Days   |   | Hrs. 8. Date of Birt                         | th c                                     | B. Birthplace (State or Foreign Country)                                |
|                        | 216-38-6913  | Yrs.                   | West and Bayo  |   | APR.20                                       | y, Year)<br>0,1941 [                     | MARYLAND  |
|                        | Usual Residence of Decedent  10a. State 10b. County 10c. City, To  | own or Lo              | ecation  |   |  |  | 10d. Inside City Limits   |
| 0                      |  |                        |  |   |  |  | 1 ☐ Yes 2 X No  |
| rect                   | MARYLAND CHARLES NAN  10e. Street and Number   | IJEM                   | 10f. Zip Code  |   |  | 10g. Citizen of Wh                       | at Country?   |
| Funeral Director       | 11855 WOODBURY ROAD  |                        | 2066   | 2                                       |  | U.S.                                     | Α.  |
| nera                   | 11. Marital Status 12. Was Decedent Ever in U.S.   | 13.                    | Was Decedent of H  | spanic Origin                           | n? (Specify Yes or No<br>Puerto Rican, etc.) | - 14. Race -                             | American Indian,  |
| F                      | 1 Never Married XX Married 1 Never Married XX Married 1 Never  | ļ                      | irYes, specify Cuba<br>1 □ Yes 2/DXNo  |   | Pueπo Hican, etc.)                           | 1  | White, etc.<br>AMERICAN   |
| d by                   | 3 ☐ Widowed 4 ☐ Divorced Year or Dates: VIETMA   | N                      | 10 105 21,7140   | Specify:                                |  |  | INDIAN  |
| ete                    | 15. Decedent's Education 16 (Specify only highest grade completed)   | (Give                  | dent's Usual Occupa<br>kind of work done   | turing most o                           | of working                                   | 16b. Kind of Busi                        | ness/Industry   |
| Completed              | Elementary/Secondary (0-12) College (1-4or 5+)   |                        | DO NOT use retired MECHAN  | ,                                       |  | GLASVA                                   | CITCO   |
|                        | 17. Father's Name (First, Middle, Last)  | 1010                   | TIDCHAM.   |   | s Name (First, Middle,                       |  |   |
| To Be                  | LEROY PERRY  |                        |  |   | ANITA HAI                                    | · ·                                      |   |
| F                      | 19a. Informant's Name/Relationship (Type, Print) 1   | 9b. Mailir             | ng Address (Street a   | and Number                              | or Rural Route Numbe                         | er, City or Town, St                     | ate, Zip Code)  |
|                        | VIRGINIA AVERS-PERRY-SPOUSE  | 11                     | 855 WOOI   | OBURY                                   | RD., NAN                                     | JEMOY, MI                                | 20662   |
|                        | come   | of Dispo               | sition (Name of<br>matory or other place   | e) !                                    | Date   | 20c. Location - Ci                       | ity or Town, State  |
|                        | MARYLAND  MARYLAND   | -                      |  | ·                                       | 2-20-05                                      | CHELTENI                                 | HAM, MD   |
|                        | 21. Signature of Funeral Service Licensee M00479   | 22                     | 2. Name and Addres   | s of Facility                           |  |  |   |
|                        | Mirhael O. Tom   | V R                    |  |   | AL SERVION                                   |  | •   |
|                        | 23a. Part1. Enter the disease, or complications that caused the death. D<br>shock, or heart failure. List only one cause on each line.   | o not ent              | er the mode of dyin  | g, such as ca                           | ardiac or respiratory ai                     | rest,                                    | Approximate<br>Interval Between   |
|                        | Immediate Cause (Final disease or condition  | 2                      | Cell   | Lu                                      | ng Can                                       | cer                                      | Onset and Death   |
|                        | resulting in death)  Due to (or as a consequence)  | ce of):                | (  | _                                       | 7  |  | ( )   |
| <u></u>                | Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence  | re off:                | Smol   | ein                                     | 7  |  | 6 mos   |
| ij                     | cause. Enter Underlying<br>Cause (Disease or injury  | oo ory.                |  |   |  |  |   |
| Examiner               | that initiated events c. Pue to (or as a consequence of the constraint of the constr | ce of):                |  |   |  |  |   |
| dicai                  | , d.   |                        |  |   |  |  |   |
| ledi                   |  |                        |  |   |  |  |   |
| by Physician/Me        | IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Fetal dec   |                        | Ectopic pregnancy  |   |  | 23d. Date (                              | ,   |
| Sici                   | 1 Yes 2 No   |                        | Other (specify)  |   |  | Month                                    | n Day Year  |
| Phy                    | 9 Unknown  | -:                     | a de de la companya d | on in Book!                             | ase Did.                                     |  | ute to the cause of death?  |
| by                     | Part II. Other significant conditions contributing to death but not resulting the death but not result not resulting the death but not resulti | y in the u             | noenying cause give  | en in Part I.                           |  |  | ☐ Probably 4 Munknown   |
| Completed              | PANCY TO PENID D<br>CHEMOTHERAPY; K  | 2 1 1                  | ATIA   |   |  |  |   |
| mpi                    | CHEMIO THERAPY; N  | AUI                    | TIDN TH  | ERAP                                    | 24a. Was autop                               | osv prio                                 | ore autopsy findings available<br>for to completion of cause of<br>ath? |
|                        | OS Was and the second to the s |                        |  |   | 1 ☐ Yes                                      | 20 No 1 L                                | Yes 2□No  |
| o Be                   | 25. Was case referred to medical examiner?  1 Vas 2 VAn  | /Out = -4:             | ot 3 DOA Othe  | 00                                      | f Death (Check only o                        |  | (0 - 11)  |
| 1: To                  | 27. Manner of Death 28a. Date of Injury 28t  | Outpatier  b. Time o   | . 00 00.   | - I I I I I I I I I I I I I I I I I I I | ing Home 5 Resident                          | now injury occurred                      |   |
| tior                   | 1 Natural 5 ☐ Pending (Month, Day Year) 2 ☐ Accident investigation   | Injury                 | f 28c, Injury<br>Work<br>M 1 []  | c?<br>Yes 2 □ No                        |  |  |   |
| iffice                 | 3 Suicide 6 Could not be determined 28e. Place of Injury - At home,  | , farm, str            | eet, factory, office   |   |  |  | or Rural Route Number,  |
| Cert                   | 4 Homicide building, etc. (Specify)  |                        |  |   | City or Tov                                  | vii, State)                              |   |
| Medical Certification; | 29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowled 2 Medicel Examiner: On the basis of examination and manner stated.  | dge, deat<br>and/or in | h occurred at the tim<br>vestigation, in my of   | ne, date and<br>pinion, death           | place, and due to the occurred at the time,  | cause(s) and mann<br>date and place, and | ner as stated.<br>d due to the cause(s)                                 |
| Me                     | 29b. Signature and title of certifier  |                        | 29c. License   | e number                                |  | 29d. Date signed (                       | Month, Day, Year)   |
|                        | I fel twochand M-1   | )                      | D-29   | 646                                     |  | 12-                                      | 15-05   |
|                        | 30. Name an address of person who completed cause of death (Item 23  |                        | •  |   |  |  |   |
|                        | Joel Sewchand, MD 101 Centennial S   | Stree                  | et, Ste.   | В, Р.О                                  | . Box 988,                                   | La Plata                                 | a, MD 20646   |

|                   |  |                  | For<br>State<br>Registrar  | State of Maryla  |                                      | artment of H   |  |  | Reg. No.   | 41617  |
|-------------------|--|------------------|--|--|--------------------------------------|--|--|--|--|--|
|                   | Physici<br>/Medio<br>Examir  | al               | Decedent's Name (First, Middle, Last     Carol Sue PLUM     4a. Facility Name (If not institution, give  |  |                                      | 4b. City, Town, or   | r Location of De                                   | 2. Date of Dea<br>Month<br>Dec           | Day Year  1 200  4c. County of Dea                                       | 5 10:11 M  |
|                   | Funeral<br>Director  |                  | 219-68-1059  |  | . last birthday)<br>Yrs.             | Hagerst If Under 1 Year Months Days                              | OWN<br>If Under 24 Hi<br>Hours Min                 | n. (Month, Da                            | Washingt<br>by Year) 9. Bi<br>22 1957Mar                                 | rthplace (State or Foreign<br>country)           |
|                   | e Maryland<br>a-f ehow   | ctor             | Usual Residence of Decedent  10a. State 10b. County  Maryland Washi  |  | ity, Town or Lo                      |  |  |  |  | 10d. Inside City Limits 1 X Yes 2 □ No           |
|                   | eth with the 23s or 28   | Funeral Director | 10e. Street and Number 214 Potomac Stre  |  |                                      | 10f. Zip Code 2171   |  |  | 10g. Citizen of What C   |  |
| 900               | within 72 hours after deeth with the Maryland<br>ene.<br>than "natural", or iteme 23e or 28e-f ehow<br>f.a Medical Examinat rusal be notified at   | 5                | 11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  | 12. Was Decedent Ever in I<br>Armed Forces?<br>1 ☐ Yes 2X No<br>If Yes, Give<br>Year or Dates: |                                      | Was Decedent of H<br>If Yes, specify Cuba<br>1 ☐ Yes 2☑ No       | lispanic Origin? I<br>an, Mexican, Pue<br>Specify: | (Specify Yes or No-<br>erto Rican, etc.) |  |  |
| 21215-0036        | d within 72 hi<br>jiene.<br>r than "natu<br>I'n Medical  | Completed        | 15. Decedent's E. (Specify only highest grade) Elementary/Secondary (0-12) 12  |  | (Give                                | dent's Usual Occup<br>kind of work done of<br>DO NOT use retired | during most of w                                   | rorking                                  | 16b. Kind of Business mortgage   |  |
| Maryland 2        | nould be filed<br>I Mental Hyg<br>nerked othe<br>natic event,  | To Be C          | 17. Father's Name (First, Middle, Last) George V. Mong,  | Jr.  |                                      |  | Doroth   | -  | eth Wolfe  |  |
|                   | ss 1 and 2 st<br>of Heelth and<br>item 27 is n<br>other traun  |                  | 19a. Informant's Name/Relationship ( Tiffany Hayes – ( 20a. Method of Disposition  | daughter 20b.  | 250                                  |  | ry St.   |  | er, City or Town, State, Stown, Md.  20c. Location - City or             | 21740  |
| Baltimore,        | permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Marylar Depertment of Heelth and Mental Hygiene. Depertment of Heelth and Mental Hygiene important: if item 27 is marked other than "natural", or iteme 23e or 28e-f show any injury or other traumatic event, the Medical Examination at any injury or other traumatic event, the Medical Examination at any once. |                  | 1 🖾 Burial 2 Cremation 3 C<br>4 Donation 5 Other (Specification of Puneral Service Licer   | (v) Ce   | dar La                               | wn Mem. P  | ark 12,  | MINNICH                                  | Hagerstown<br>FUNERAL HO<br>stown, Md.                                   | ME   |
|                   | Physician<br>/Medical<br>Examiner  |                  | 23a. Part1. Enter the disease, or comshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)                    | a  | lul .                                | ter the mode of dyin   |  |  |  | Approximate Interval Between Onset and Death     |
| 8760,             | icate be executed physicien and sthe burial-transit  | ical Examiner    | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Due to (or as a conse c. Due to (or as a conse d.   |                                      |  |  |  |  |  |
| P.O. Box 68       | death certif<br>e attending<br>ed for use as   | Physician/Med    | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown  | 23c. If yes, outcome of pregr<br>1 Live birth 2 Fet<br>4 Pregnant at time of<br>9 Unknown      | al death 3                           | □Ectopic pregnancy<br>□ Other (specify)                          | ,  |  | 23d. Date of de<br>Month   | slivery<br>Day Year                              |
| Records, P        | The law requires that the de<br>ete has been signed by the a<br>page 2 should be detached  | by               | Part II. Other significant conditions of   | ontributing to death but not re  | sulting in the u                     | inderlying cause give  | en in Part I.                                      |  | obacco use contribute t<br>res 2 □ No 3 □ P                              | to the cause of death?                           |
| al Rec            | Physician: The law requires that the this certificete has been signed by the tall director, page 2 should be detach  | e Completed      | 05 Was asset to the second   |  |                                      |  |  | 1 Yes                                    | prior to death?  | utopsy findings available completion of cause of |
| Division of Vital | Jing<br>After  | To B             | 25. Was case referred to medical examiner?  1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending 2 Accident investigation                                   | 28a. Date of Injury<br>(Month, Day Year)   | ER/Outpatie<br>28b. Time o<br>Injury | f 28c. Injun<br>Wor  | er: 4 🗆 Nursing                                    | -  | dence 6 Other (Spenow injury occurred                                    | ecify)   |
| Divis             | To the Hospitel or Attent within 24 hours after death To the Funaral Director; completely filled in by the   | Certification:   | 3 Suicide 6 Could not b<br>4 Homicide determined   | building, etc. (Spec   | ify)                                 |  |  | City or Tow                              | 10.  |  |
|                   | To the Hospitei<br>within 24 hours a<br>To the Funarai I<br>completely filled  | Medical          | 29a. Certifier (Check only one)  1 Certifying Ph 2 Medical Exar 29b. Signature and title of certifier  | ysician: To the best of my kr<br>niner: On the basis of examin<br>and manner stated.           | iowledge, deal<br>ation and/or in    | th occurred at the tin<br>evestigation, in my o                  | pinion, death oc                                   | curred at the time,                      | cause(s) and manner a<br>date and place, and du<br>29d. Date signed (Mon | e to the cause(s)                                |
|                   |  |                  | 30. Name and address of person who   | completed cause of death (Ite  | m 23a) (Type,                        | Print)   | 5036   | 2  | 12-12  |  |
| 9                 | H-ID<br>Sta<br>Regist  |                  | 31. Date filed (Month, Day, Year) DEC 132  | 22911<br>32. Registrar's Sign  | yeurs<br>interes                     | on Blod  | l Hry  | md-                                      |  |  |

|                                 |   |                   | For State  | State of Ma                           |              | d / Depa                     |                            | nt of H              | ealth a             |            | ental Hygie                      | 2005                                  | 5           | 41618  |
|---------------------------------|---|-------------------|--|---------------------------------------|--------------|------------------------------|----------------------------|----------------------|---------------------|------------|----------------------------------|---------------------------------------|-------------|--|
|                                 | 1-110-  |                   | Registrar  |                                       |              | 061                          | uncai                      | e or L               | Jealii              |            | Reg<br>2. Date of Death          | No.                                   |             | 3. Time of Donth                             |
|                                 | Physicia  | an                | Decedent's Name (First, Middle, Last)  |                                       |              |                              |                            |                      |                     |            | Month                            |                                       | 'ear        | 3. Time of Death                             |
|                                 | /Medic  |                   | GENEVA   | IRENE                                 | PALME        | R                            |                            |                      |                     |            | December                         | · · · · · · · · · · · · · · · · · · · | 05          | 5:23 A M                                     |
|                                 | Examin  | er                | 4a. Facility Name (If not institution, give str  |                                       | _            |                              |                            | _                    | Location o          | f Death    |                                  | 4c. County of                         |             |  |
|                                 |   | 18-12             | Frederick Memorial   | Hospita                               | 1            |                              |                            | deri                 | _                   |            |                                  | Freder                                |             |  |
|                                 | Funeral<br>Director   |                   | 5. Social Security Number 6. Sex 1 Number 217-32-7164  | 7. Age                                | 94           | rst birthday)<br>Yrs.        | If Under<br>Months         | Days                 | If Under 2<br>Hours | Min.       | B. Date of Birth (Month, Day, Y) | 1911                                  |             | lace (State or Foreign<br>try)<br>RYLAND     |
|                                 | and w   |                   | 10a. State 10b. County   |                                       | 10c. City,   | , Town or Lo                 | cation                     |                      |                     |            |                                  |                                       | 1           | 0d. Inside City Limits                       |
|                                 | lary  | 5                 | MADVI AND EDEDEDIC   | r                                     |              |                              |                            | DDI                  | 71 DU T             | OT 2       |                                  |                                       |             | 1 ☐ Yes 2 X No                               |
|                                 | 788-1   | Director          | MARYLAND   FREDERICE  10e. Street and Number   |                                       |              |                              | 10f. Zip                   |                      | EDERI               | UK         | 100                              | . Citizen of Wh                       | at Coun     | tor?   |
|                                 | The second  | ā                 |  |                                       |              |                              | 101. 2.1                   |                      | 24 7 0 0            |            | 1.09                             |                                       |             | ,  |
|                                 | death with the Maryland<br>me 23a or 28a-f ehow<br>r must be routted at   | Funeral           | 7407 WILLOW ROAD   |                                       | - · · · · ·  | 140.1                        |                            |                      | 21702               |            | # Was as No                      | 14. Race -                            | .S.A        |  |
|                                 | er de   | nu                | THE STATE OF THE S | . Was Decedent I<br>Amed Forces?      |              | s. 13. 1                     | f Yes, spe                 | cify Cubar           | n, Mexican          | , Puerto R | ify Yes or No-<br>ican, etc.)    |                                       | White,      |  |
| 36                              | or i  | by F              | 1 Never Married 2 Married 3 X Widowed 4 Divorced   | 1 ☐ Yes 2 🔯 N<br>If Yes, Give         | NO           |                              | 1 🗆 Yes                    | 2 <b>⊠</b> No        | Specify:            |            |                                  | Specify:                              |             |  |
| 0                               | ure!  |                   |  | Year or Dates:                        |              | 10- 0                        | 4                          |                      |                     |            | 100                              | - 10'- 4 - 4 D 1                      |             | HITE   |
| ιγ                              | be filed within 72 hours after death with the Marylan Hygiene.  d at Hygiene.  d other than "naturelt, or itame 23a or 28a-f show event, it a Maritial Examinar must be notified at | Completed         | 15. Decedent's Educa<br>(Specify only highest grade of   | completed)                            |              | 16a. Deced                   | kind of wo<br>DO NOT u     | rk done d            | lurina most         | of workin  | g                                | b. Kind of Busi                       | ness/inc    | ustry  |
| 2                               | hen ne  | ш                 | Elementary/Secondary (0-12)  | College (1-4or 5                      | i+)          | me.                          |                            |                      |                     |            |                                  | 07.7                                  |             |  |
| 7                               | filed v<br>Hygie<br>other t   |                   | 17. Father's Name (First, Middle, Last)  |                                       |              |                              | HO                         | MEMAL                |                     | de Nomo    | (First, Middle, Ma               |                                       | N HO        | ME   |
| n<br>n                          | tai H<br>d ot<br>d ot   | Be                |  |                                       |              |                              |                            |                      |                     |            |                                  |                                       |             |  |
| <u>X</u>                        | should be<br>ind Menta<br>marked<br>umatic ev   | ို                | GEORGE EDGAR SHANK   |                                       |              |                              |                            |                      |                     |            | E PALMER                         |                                       |             |  |
| Maryland 21215-0036             | 2 a e a   |                   | 19a. Informant's Name/Relationship (Type   |                                       |              |                              | •                          | •                    |                     |            | Route Number, C                  |                                       |             |  |
|                                 | and<br>Balth<br>n 27  |                   | ETHEL ROTHENHOEFER   | DAUGHTER                              |              |                              |                            |                      | E DRI               |            | REDERICE                         |                                       |             |  |
| altimore,                       | 00  |                   | 20a. Method of Disposition 1   ☐ Burial 2 ☐ Cremation 3 ☐ Ref  | moval from State                      | 20b. Pla     | ace of Dispo<br>metery, crer | isition (Na<br>matory or d | me of<br>other place | 9)                  | Da         | te 20                            | c. Location - C                       | ty or To    | wn, State                                    |
| Ĕ                               | permit. Pages<br>Department of I<br>Important: If It<br>any injury or o   |                   | 4 Donation 5 Other (Specify)   | HOVAL HOLL State                      | ZIO          | N LUT                        | HERAN                      | CEM                  | ETERY               | 12/1       | 2/05 M                           | IDDLETO                               | WN.         | MARYLAND                                     |
| 三                               | permit. Departm Imports any inju  |                   | 21. Signature of Jungral Service Licensee  |                                       |              | 22                           | 2. Name a                  | nd Addres            | s of Facility       | у -        | 7606 01d                         |                                       |             |  |
| Ö                               | Depar<br>Depar<br>Impor<br>any in   |                   | IN MILLA   | Paul I                                | M. De        | an B                         | AST F                      | UNER                 | AL HO               |            | Boonsbor                         |                                       |             |  |
| 6                               | 2   |                   | 23a. Part1. Enter the disease of complica  | itions that caused                    | the death.   | . Do not ent                 | er the mod                 | de of dying          | g, such as          |            |                                  |                                       |             | Approximate                                  |
| 1 4                             |   |                   | shock, or heart failure. List only one<br>Immediate Cause (Final   | cause on each lin                     | 10 5         | 104                          | 1 5                        |                      |                     |            |                                  |                                       |             | Interval Between<br>Onset and Death          |
| Fa.                             | Physician<br>/Medical   |                   | disease or condition a. resulting in death)  | 00                                    |              | J                            |                            |                      | , /                 | ,          |                                  |                                       |             |  |
|                                 | Examiner  |                   |  | Due to (or as                         | 1            |                              | nal                        |                      | lail                | ure        |                                  |                                       |             |  |
| ľ                               |   | -                 | Sequentially list conditions, b.   | Due to (or as                         | V            |                              | nul                        |                      | ( ) [               |            |                                  |                                       |             |  |
|                                 | ed sit  | ine               | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that injuried avoids.  |                                       | hil          | 25.4                         | (570                       | ,                    |                     |            |                                  |                                       |             |  |
|                                 | and<br>and<br>I-tran  | Examiner          | that initiated events c. resulting in death) Last  | Due to (or as                         | consequ      | ence of):                    |                            |                      |                     |            |                                  |                                       |             |  |
| 0                               | te be executed<br>ysicien and<br>te burial-transit  |                   |  | Atril                                 | 11           | 11                           | 4                          | in                   |                     |            |                                  |                                       |             |  |
| 87                              | A > 0   | dicai             | 0  | (1)                                   | 7            | 1.6.17.1                     | SIA                        | U.V.                 | 1272                |            |                                  |                                       | -           |  |
| × 68                            | e as  | Me                | IF FEMALE:   | 40.31 014.383                         |              |                              |                            |                      |                     |            |                                  |                                       |             |  |
| Box                             | ath c   | any               | 23b. Was decedent pregnant in the past 12 months?  | If yes, outcome<br>1☐Live birth       | 2 Fetal      | déath 3[                     | Ectopic p                  |                      |                     |            |                                  | 23d. Date                             |             | ry<br>Day Year                               |
| <u>.</u>                        | e de<br>the a   | sic               | 1 ☐ Yes 2 ☑ No<br>9 ☐ Unknown  | 4□Pregnant at<br>9□Unknown            | time of de   | ath 5L                       | Other (s                   | овсіту)              |                     |            |                                  |                                       |             | •  |
| <u>ч</u>                        | of the  | P.                |  |                                       |              |                              |                            |                      |                     |            | an- Didustra                     |                                       |             | 4.1.110                                      |
| Division of Vital Records, P.O. | The law requires that the death certifica<br>sie has been signed by the attending ph<br>page 2 should be detached for use as th   | by Physician/Medi | Part II. Other significant conditions contr  | ibuting to death b                    | ut not resu  | Iting in the u               | nderlying                  | cause give           | en in Part I.       |            |                                  |                                       |             | e cause of death?                            |
| ב                               | w require<br>been si<br>should t  | ed                |  | · · · · · · · · · · · · · · · · · · · |              |                              |                            |                      |                     |            | 1 L Yes                          | _2.₽1No 3                             | ☐ Prob      | ably 4 Dunknown                              |
| ပ္ထ                             | ne lawr<br>has be<br>ge 2 sh  | Completed         |  |                                       |              |                              |                            |                      |                     |            | 24a. Was an autopsy              | 24b. We                               | ere autor   | osy findings available inpletion of cause of |
| Œ                               | The his   | E                 |  |                                       |              |                              |                            |                      |                     |            | performe                         | d? dea                                | ath?<br>Yes |  |
| ā                               | an:<br>tifica<br>tor, p   | a)                | 25. Was case referred to medical   |                                       |              |                              |                            |                      | 26. Place           | of Death   | Check only one                   |                                       |             |  |
| >                               | yeici<br>s cer<br>direc   | ToB               | examiner?  | spital: Inpatie                       | ent 2 🗆 E    | R/Outpatier                  | nt 3□ D                    | OA Othe              | or: 4 □ Nu          | rsina Hom  | e 5 ☐ Residend                   | e 6 ∏Other                            | (Specify    | 1)   |
| 6                               | a Ph  | _ :-              | 27. Manner of Death  | 28a. Date of Inju<br>(Month, Da       | ry           | 28b. Time o                  | f :                        | 28c. Injury<br>Work  |                     |            | 3d. Describe how                 |                                       | · · · · · · | ,  |
| O                               | th.   | ţ                 | Natural 5 Pending 2 Accident investigation   | (Month, Da)                           | y rear)      | Injury                       | М                          |                      | (/<br>Yes 2 □ !     | No         |                                  |                                       |             |  |
| S                               | Attending Physician: or death, ector: After this certifics by the funeral director, p   | fice              | 3 ☐ Suicide 6 ☐ Could not be   | 28e. Place of Inju                    | ury - At hor | me, farm, sti                | reet, factor               | y, office            |                     | 2          | Bf. Location (Stre               | et and Number                         | or Rura     | l Route Number,                              |
| Š                               | efter<br>Dire   | Certification:    | 4 Homicide   | building, et                          | c. (Specify, | )                            |                            |                      |                     |            | City or Town,                    | State)                                |             |  |
|                                 | Hospital or<br>24 hours efte<br>Funeral Dir<br>tely filled in I   |                   | 29a. Certifier 12 Certifying Physic  | cian: To the best                     | of my knov   | vled de. deat                | h occurred                 | at the tim           | ne. date an         | d place, a | nd due to the cau                | se(s) and mann                        | ner as st   | ated   |
|                                 | To the Hospital or Attending Physician: The I within 24 hours effer death. To the Funeral Director: After this certificate ha completely filled in by the tuneral director, page    | Medicai           | (Check only 2 Medical Examine  | or: On the basis of                   | f examinati  | ion and/or in                | vestigation                | n, in my op          | pinion, deal        | th occurre | d at the time, date              | and place, an                         | d due to    | the cause(s)                                 |
|                                 | To the within 2 To the complet  | ĕ.                | 29b. Signature and title of certifier  | _                                     |              |                              | 29                         | c. License           | number              |            | 290                              | . Date signed (                       | Month, I    | Day, Year)                                   |
|                                 | r s ⊢ ō   |                   | · Mulal.   | M                                     | D            |                              |                            | Do                   | 06                  | 08         | 711                              | 2/9                                   | 1.          | ~  |
| ,                               |   |                   | 30. Name and address of person who com   | C pleted gauge of d                   | leath /lear  | 23a) (Tuno                   | Print\                     |                      | -                   |            | 1                                |                                       | 10          | >  |
| 41                              | 1-4   |                   |  |                                       |              |                              |                            | Ctwo                 | oct 1               | Erodo      | riola Ma                         | rul and                               | 21          | 7∩1  |
|                                 | Sta   | 10                | Michelle Tan, M.D.  31. Date filed (Month, Day, Year)  |                                       | 1 01         |                              |                            |                      | دد,                 | rrede      | rick, Ma                         | тутани                                | <u> </u>    | I OT   |
| 7                               | Regist  |                   | DEC 1320   | 05                                    | 2200         | M. A                         | beth                       |                      |                     |            |                                  |                                       |             |  |
| 0.00                            |   | 100               |  | The same of the                       |              |                              |                            |                      |                     |            |                                  |                                       |             |  |

DHMH 17 Rev 1/2001

|                   |   |                   | 1 - For<br>State<br>Registrar   |   | aryland /                        |                   | rtment of F                           | lealth and M<br>Death                        |  | iene) 05                           | 41619  |
|-------------------|---|-------------------|---|---|----------------------------------|-------------------|---------------------------------------|--|--|------------------------------------|--|
| П                 | Physicia  | an                | Decedent's Name (First, Middle  |   |                                  |                   |                                       |  | <ol><li>Date of Deat<br/>Month</li></ol> | h<br>Day Year                      | 3. Time of Death                                   |
|                   | /Medic  | al                | Charles 4a. Facility Name (If not institution   | Seaborn sive street and number          |                                  | Park              |                                       | or Location of Death                         | December                                 | 5, 2005<br>4c. County of Death     | 3:15 A <sup>M</sup>                                |
|                   | Examin  | er                | Charlotte Hall  |   | ome                              |                   |                                       | irlotte Ha                                   | 11                                       | St. Ma                             |  |
| 100               | Funeral   |                   | 5. Social Security Number   | 6. Sex 7. Ag                            | je (In yrs. last b               | irthday)          | If Under 1 Year<br>Months Days        | If Under 24 Hrs.<br>Hours Min.               | 8. Date of Birth<br>(Month, Day,         |                                    | place (State or Foreign<br>intry)                  |
| ı.                | Director  |                   | 579-52-7522   | 1 <b>X</b> M 2□F                        | 99                               | Yrs.              | Days                                  | 110013                                       | June 24,                                 | 1906 Sout                          | h Carolina   |
|                   | land  |                   | Usual Residence of Decedent  10a. State 10b. County   |   | 10c. City, Tov                   | wn or Lo          | cation                                |  |  |                                    | 10d. Inside City Limits                            |
|                   | be filed within 72 hours after death with the Maryland ntal Hygiene. sd othar than "natural", or Itams 23c or 28a-f show avant, the Medical Evan fret must be notified at | tor               | Maryland St   | . Mary's                                |                                  | Cha               | rlotte H                              | la 1 1                                       |  |                                    | 1 ☐ Yes 2 ☐XNo                                     |
|                   | or 284  | Funeral Director  | 10e. Street and Number  | Ň                                       |                                  |                   | 10f. Zip Code                         |  | 10                                       | Og. Citizen of What Cou            | intry?   |
|                   | ath wi  | rai               | 29449 Charlotte   | e Hall Road                             |                                  |                   |                                       | 1622   |  | U.S                                | .A.  |
|                   | er de<br>Itams  | une               | 11. Marital Status  | 12. Was Decedent<br>Armed Forces        | )                                | 13. V             | Vas Decedent of H<br>Yes, specify Cub | Hispanic Origin? (Spe<br>an, Mexican, Puerto | cify Yes or No-<br>Rican, etc.)          | 14. Race - Amer<br>Black, White    |  |
| 36                | urs aft   | by F              | 1 ☐ Never Married 2 ☐ Man<br>3 💢 Widowed 4 ☐ Divorced   | If Yes Give                             | NO                               | 1                 | □Yes 2 No                             | Specify:                                     |  | Specify: Wh                        | ite  |
| 21215-0036        | 72 hou  |                   |   | it's Education                          | 16a                              | a. Deced          | ent's Usual Occup                     | pation                                       |  | 16b. Kind of Business/l            |  |
| 21                | within 7<br>ene.<br>than "r   | Completed         | Elementary/Secondary (0-12)   | College (1-4or                          | 5+)                              |                   |                                       | during most of worki<br>d)                   | ng                                       |                                    |  |
| 22                | filed w<br>Hygien<br>thar tl  | S                 | 17. Father's Name (First, Middle,   |   |                                  | НО                | using In                              |  | (Cinna Adindalla A                       | D.C. Gov                           | ernment  |
| anc               | d be f<br>antal h<br>ced of   | To Be             | John Hexter Par   |   |                                  |                   |                                       | 18. Mother's Name                            | _  |                                    | لسواه  |
| Maryland          | 2 should be and Menta Is marked aumatic a   | ř                 | 19a. Informant's Name/Relations   | -                                       | 19                               | b. Mailin         | g Address (Street                     | and Number or Rura                           | A Fill S L F U                           | ng Westmor City or Town, State, Zi | eland<br>p Code) 20772                             |
|                   | nd 2<br>lith a<br>27 is<br>r tra  |                   | Betty_Oberman/  | Daughter                                |                                  |                   |                                       |  |  | r Marlboro                         |  |
| ore               | es 1 a<br>of Hea<br>fitem<br>rotha  |                   | 20a. Method of Disposition  1X Burial 2 ☐ Cremation   | 3 Demoval from State                    | 20b. Place                       | of Dispos         | sition (Name of patory or other place |  |  | 20c. Location - City or T          |  |
| Ë                 | Pages<br>Iment of<br>tant: If it<br>jury or o   |                   | `4 □Donation 5 □ Other (S   |   |                                  | ton               | National                              | Cem 01-3                                     | 0-06 A                                   | rlington,                          | Virginia   |
| Baltimore,        | permit. Pages<br>Department of<br>Important: If i<br>any injury or<br>once.   |                   | 21. Signature of Funeral Service  | Licensee MOO                            |                                  | 22.               | Name and Addre                        | ess of Facility                              | P.O.                                     | Box 156                            | = 7.0  |
| 45                |   |                   | 23a. Part1. Enter the disease, or   | complications that cause                | d the death Do                   |                   |                                       | eral Home                                    |  | rf, Maryla                         |  |
|                   | Dhusisian   |                   | shock, or heart failure. List<br>Immediate Cause (Final   | only one cause on each I                | ne.                              | THOI OTHE         | in the mode of dyn                    | ig, such as cardiac o                        | i respiratory arre                       | ot,                                | Approximate<br>Interval Between<br>Onset and Death |
|                   | Physician<br>/Medical   |                   | disease or condition resulting in death)  | a. Due to for a                         | Consequence                      | 1/4               | )                                     |  |  |                                    |  |
|                   | Examiner  |                   | O   | Des                                     | hule                             | (                 | grar                                  |  |  |                                    |  |
|                   | D #   | iner              | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | Due to (or as                           | a consequence                    |                   |                                       |  | - 110_1                                  |                                    |  |
|                   | ecute<br>and<br>trans   | Examiner          | Cause (Disease or injury that initiated events resulting in death) Last                                     | ) c                                     | unin                             |                   |                                       |  |  |                                    |  |
| 8760,             | cate be executed<br>physician and<br>the burial-transit   |                   | Transfer of the second  | Due to (or as                           | a consequence                    | or):              |                                       |  |  |                                    |  |
| 687               | tificate<br>ng phys<br>as the   | Physician/Medical |   | d                                       |                                  |                   |                                       |  |  |                                    |  |
| Вох               | ndir<br>use   | ΝŽ                | IF FEMALE:<br>23b. Was decedent pregnant  | 23c. If yes, outcome                    |                                  |                   |                                       |  |  | 23d. Date of deliv                 | ery  |
|                   |   | sicia             | in the past 12 months?<br>1 ☐ Yes 2 ☐ No  | 4□Pregnant a                            | 2 Fetal death                    |                   | Ectopic pregnancy<br>Other (specify)  | У  |  | Month                              | Day Year   |
| P.0               | that the de<br>ed by the<br>detached  | Phys              | 9 Unknown   |   |                                  |                   |                                       |  |  |                                    |  |
|                   | se un light   | by                | Part II. Other significant condition  | ons contributing to death t             | out not resulting                | in the un         | derlying cause giv                    | ren in Part I.                               | 11                                       | acco use contribute to             |  |
| Ö                 | w requii  | etec              |   | <u> </u>                                | ·                                |                   |                                       |  |  |                                    | bably 4 bhknown                                    |
| of Vital Records, | e la<br>has<br>je 2   | Completed         |   |   |                                  |                   |                                       |  | 24a. Was an autopsy perform              | prior to co                        | opsy findings available<br>empletion of cause of   |
| <u>a</u>          | ician: Th<br>certificate<br>rector, pag   | e Co              | 25. Was case referred to medica   |   |                                  |                   |                                       | 60 Pt / P //                                 | 1 ☐ Yes 2.                               | ☑No 1□Yes                          | 21 No  |
| <u> </u>          | Physician:<br>this certific<br>ral director,  | To B              | examiner?   | Hospital:                               | ent 2 ER/O                       | utoatient         | 3□ DOA Oth                            | 26. Place of Death                           |  | nce 6 □Other (Speci                | 6.1  |
|                   | ding Ph<br>h.<br>After thi<br>funeral   |                   | 27. Manner of Death Natural 5 Pendir  | 28a. Date of Inju                       | iry 28b.                         | Time of<br>Injury | 28c. Injur<br>Wor                     | y at   |  | w injury occurred                  | (97)   |
| Sio               | Attanding<br>r death.<br>actor: After<br>by the fune  | catic             | 2 Accident investi  | gation                                  |                                  | ,,                |                                       | Yes 2 □ No                                   |  |                                    |  |
| Division          | or Att  | ertification;     | 3 ☐ Suicide 6 ☐ Could<br>4 ☐ Homicide determ  | 28e. Place of in                        | ury - At home, f<br>c. (Specify) | arm, stre         | et, factory, office                   | 2  | 28f. Location (Str.<br>City or Town,     | eet and Number or Run<br>State)    | al Route Number,                                   |
|                   | Hospital or Attanding I<br>24 hours after death.<br>Funeral Diractor: After<br>tely filled in by the funer  | O                 | 29a. Certifier 12 Certifyin   | ng Physician: To the best               | of my knowledg                   | a death           | occurred at the tire                  | mo data and alaa, a                          | and due to the ex-                       | (-)                                |  |
|                   | To the Hospital or Attan within 24 hours after deat To the Funeral Diractor: completely filled in by the  | edical            | (Check only 2 Medical one)  | Exeminer: On the basis of and manner st | t examination ai                 | nd/or inv         | estigation, in my o                   | ppinion, death occurre                       | ed at the time, da                       | te and place, and due t            | o the cause(s)                                     |
|                   | To the within 2 To the Complet  | Me                | 29b. Signature and title of certifie  | . 1                                     |                                  |                   | 29c. Licens                           | e number                                     | 29                                       | d. Date signed (Month.             | Day, Year)   |
| )                 |   |                   | ) / U   |   |                                  |                   | Doo                                   | 61941  |  | 178/5                              |  |
| 1                 | h nel   |                   | 30. Name and address of person  |   |                                  |                   | •                                     |  |  |                                    |  |
|                   | ار<br>Sta   | 10                | Manoj Mathur,<br>31. Date filed (Month, Day, Year)  | MD., 29449                              | Charlot                          | te H              | all Road                              | , Charlot                                    | te Hall.                                 | Maryland,                          | 20622  |
| 9                 | Registr   |                   | DEC 0   | 9 2005                                  | م روده                           | 1. 1              | porte                                 |  |  |                                    |  |
|                   |   |                   |   |   |                                  |                   |                                       |  |  |                                    |  |

|                          |  |                | For State   | State of Mary   | land / Depa                               | artment of He<br>rtificate of D                                     | ealth and M                                 | ental Hyg                                   | iepen 05                                  | 41620   |
|--------------------------|--|----------------|---|---|---|---|---|---|---|---|
|                          |  |                | Registrar  1. Decedent's Name (First, Middle, Las   | st)   | Cel                                       | Timcate of L  | realli                                      | 2. Date of Deat                             | eg. No.                                   | 3. Time of Death  |
|                          | Physici  |                | Marjorie Carol  | Pellegrini  |   |   |   | Month<br>Decembe                            | er 8, 200                                 | ar  |
|                          | /Medic<br>Examin   |                | 4a. Facility Name (If not institution, give   |   |   | 4b. City, Town, or L  | Location of Death                           | 2000  | 4c. County of D                           |   |
| _,,                      | - B- B-W   |                | Gilchrist Hospice   |   |   | Towson  |   |   | Baltimo                                   |   |
|                          | Funeral  |                | 5. Social Security Number 6. S  | ex 7. Age (In   | yrs. last birthday)                       | Months Days   | If Under 24 Hrs.<br>Hours Min.              | 8. Date of Birth<br>(Month, Day,            | Year) 9.                                  | Birthplace (State or Foreign<br>Country)                |
| ę                        | Director   |                | 212-52-8846 Usual Residence of Decedent   |   | 60 Yrs.                                   |   |   | Apr 28,                                     | , 1945 M                                  | aryland   |
|                          | ylanc<br>how   |                | 10a. State 10b. County  | 10  | c. City, Town or Lo                       | ocation   |   |   |   | 10d. Inside City Limits                                 |
|                          | Ba-f-  | Director       | Maryland Howard   | We  | oodstock                                  |   |   |   |   | 1 ☐ Yes 2 XNo   |
|                          | with th  | Dire           | 10e. Street and Number  |   |   | 10f. Zip Code   |   | 1   | 0g. Citizen of What                       | Country?  |
|                          | eath v   | eral           | 10700 Hillingdon  | Road  12. Was Decedent Ever   | tin II C 42 1                             | 21163   | i- Ori-i-2 (C                               |   | JSA                                       |   |
| 36                       | permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturel", or Items 23s or 28s-f ehow supt fully or other traumatic event, the Musical Esta circuit by mulliact at QDCs. | by Funeral     | 11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced   | Amed Forces?  1  Yes, 2 No If Yes, Give Year or Dates:                            |   | Was Decedent of His<br>If Yes, specify Cuban<br>1 ☐ Yes 2112 No     | Specify:                                    | Rican, etc.)                                | Black, V                                  | merican Indian,<br>/hite, etc.<br>nite                  |
| Maryland 21215-0036      | 72 hou   | Completed      | 15. Decedent's Ed   | Jucation  | 16a. Deced                                | dent's Usual Occupat  | tion  |   | 16b. Kind of Busine                       |   |
| 218                      | thin 7   | nple           | (Specify only highest gra   | College (1-4or 5+)  | life.                                     | dent's Usual Occupat<br>kind of work done du<br>DO NOT use retired) | iring most of workii                        | ng  |   |   |
| 121                      | lygien<br>lygien<br>her th   | Con            |   | 2   | Regis                                     | stered Nur  |   |   | Healthca:                                 | re  |
| and                      | ntal H   | Be             | 17. Father's Name (First, Middle, Last) Walter Carroll Mi   |   |   |   | 18. Mother's Name                           |   | ,   |   |
| 7                        | should<br>nd Me<br>mark<br>matic   | ဥ              | 19a. Informant's Name/Relationship  |   | 19b Mailir                                | ng Address (Street ar   | Mildred 1                                   |   |   | e Zin Code)   |
| Ma                       | nd 2 salth ar 27 is r trau   |                | John M. Pellegrin   | •   |   | Hillingd  |   |   |   |   |
| Baltimore,               | Pages 1 a<br>ent of Hea<br>nt: If item<br>ry or othe   |                | 20a. Method of Disposition 1 ☐ Burial 2 🏹 Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specification of the control | Removal from State  |   | sition (Name of matory or other place)                              |   |   | 20c. Location - City Seltsville           |   |
| Baltii                   | Departm<br>Departm<br>Importar<br>any injur  |                | 21. Signature of Funeral Septice Licen  |   |   | Name and Address<br>oing Home                                       |   |   |   |   |
| 1. 4                     | 11000000   |                | 23a. Part 1. Enter the disease, or com  | plications that caused the  | 401251 Be                                 | verly L.  | Heckrotte                                   | P.A.  | Clarksvi                                  | Lle, MD 21029 Approximate                               |
| 3                        | Dhysisian  |                | Immediate Cause (Final  | one cause on each line.   | cal                                       |   | /   |   | ,   | Interval Between<br>Onset and Death                     |
| Ű.                       | Physician<br>/Medical  |                | disease or condition resulting in death)  | a. Due to (or as a co   | insequence of):                           | J mgci  | VA CLE                                      | gener                                       | ntion                                     | year  |
|                          | Examiner   |                | Sequentially list conditions  | h   | ,   |   | -   | ,   |   |   |
| 78                       | <b>₽</b> ∺   | Iner           | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury   | Due to (or as a co  | nsequence of):                            |   |   |   |   |   |
|                          | and<br>and<br>I-trans  | Examiner       | that initiated events resulting in death) Last  | c<br>Due to (or as a co   | nonguana of                               |   |   |   |   |   |
| 60,                      | icate be executed<br>physician and<br>s the burial-transit   |                |   | Due to (or as a co  | risequerice di).                          |   |   |   |   |   |
| 68760,                   |  | edical         |   | d   |   |   |   |   |   |   |
| P.O. Box                 | death cert<br>e attendin<br>d for use  | Physician/M    | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown   | 23c. If yes, outcome of pr<br>1 Live birth 2 1<br>4 Pregnant at time<br>9 Unknown | Fetal death 3                             | Ectopic pregnancy Other (specify)                                   |   |   | 23d. Date of<br>Month                     | delivery<br>Day Year                                    |
| S, P                     | ss that<br>gned b  | by Pr          | Part II. Other significant conditions of  | ontributing to death but no   | ot resulting in the u                     | nderlying cause given   | n in Part I.                                | 23e. Did tob                                | pacco use contribute                      | to the cause of death?                                  |
| ord                      | equire<br>sen si<br>lould b  |                |   |   |   |   |   | 1 □ Ye                                      | s 2 0 100 3 0                             | Probably 4 Unknown                                      |
| Division of Vital Record | The law requires that the ale has been signed by the page 2 should be detache  | Completed      |   |   |   |   |   | 24a. Was ar<br>autops<br>perform<br>1 Yes 2 | y prior                                   | autopsy findings available to completion of cause of ?? |
| Vita                     | ician:<br>sertific<br>ector,   | Be             | 25. Was case referred to medical examiner?  | Hometal   |   |   | 26. Place of Death                          | (Check only on                              | θ)  | 11  |
| of                       | Phys<br>this<br>al dir   | - T            | 1 Yes 2 No  | Hospital:  1  Inpatient  28a. Date of Injury                                      | 2 ER/Outpatien                            |   | 4   Nursing Hon                             |   | nce 6 Other (S                            | pecify) + 85 pi &                                       |
| on                       | Attending Physician: Ir death. ector: After this certifici<br>by the funeral director, i   | tlon           | 1 Natural 5 Pending 2 Accident investigation  | (Month, Day Ye  | ar) Injury                                | Work?   | es 2 No                                     | 8d. Describe no                             | w injury occurred                         |   |
| Visi                     | Atter<br>ector<br>by the   | Certification: | 3 Suicide 6 Could not be determined   |   | At home, farm, str                        |   |   | 8f. Location (Str                           | reet and Number or                        | Rural Route Number,                                     |
| ā                        | Hospital or A<br>14 hours after<br>Funeral Dire<br>tely filled in b  |                |   |   |   |   |   | City or Town                                |   |   |
|                          | To the Hospital or Attending Physician: The law within 24 shouts after death. To the Funeral Director Atter this certificate has completely filled in by the funeral director, page 2  | edical         | 29a. Certifier 1 S Certifying Ph<br>(Check only one) 2 Medical Exam   | ysician: To the best of my<br>niner: On the basis of exa<br>and manner stated.    | y knowledge, death<br>mination and/or inv | occurred at the time<br>vestigation, in my opin                     | n, date and place, a<br>nion, death occurre | nd due to the ca<br>od at the time, da      | use(s) and manner<br>ate and place, and o | as stated.<br>due to the cause(s)                       |
|                          | To the within 2 To the complet   | ×              | 29b. Signature and little of certifier  | 1 - 1-  | 0   | 29c. License  | number                                      |   | 9d. Date signed (Me                       |   |
| -                        |  |                | 1/1/11  | my in   | az, m                                     | UVX   | - 2003                                      |   | 18 Centre                                 | 1 2005  |
| 10                       | the  |                | 30. Name and address of person who  | 1 GBMC  | 6701/                                     | V. Charl  | Best,                                       | Bolto                                       | and .                                     | 21204   |
|                          | Sta<br>Registr   |                | 31. Date filed (Month, Day, Year)   | 32. Registrar's S   | olynature                                 | breet 1   |   |   |   |   |

felle 6,2111, Marginis 12.08.2005 9+3/441

|                                 |   |                           | For State   | State of                    | f Marylan                            |                             | artment of Hertificate of D                  |                             | Mental Hy          | Em 5            | 005                         | 41621  |
|---------------------------------|---|---------------------------|---|-----------------------------|--------------------------------------|-----------------------------|--|-----------------------------|--------------------|-----------------|-----------------------------|--|
|                                 |   |                           | Ragistrar  1. Decedent's Name (First, Middle, L   | ast)                        |                                      | 00,                         | tinoato oi E                                 |                             | 2. Date of D       | Rag. No.        |                             | 3. Time of Death                                 |
| ۵.                              | Physicia  | an                        | Albert Francis  |                             | n                                    |                             |  |                             | Deern              | Day             | 8 2005                      | 1810 M   |
| S                               | /Medic<br>Examin  |                           | 4a. Facility Name (If not institution, g  |                             |                                      |                             | 4b. City, Town, or                           | Location of Dea             |                    |                 | County of Death             | 1270   |
|                                 | Examin  | er                        | 0- 10-  | nal Nel                     | tical la                             | enter                       | Sali   | chial                       |                    |                 | Nicon                       | ico  |
| -3                              | Funeral   |                           | FENINSULA LEGIU<br>5. Social Security Number 6.   |                             | 7. Age (In yrs.                      | ast birthday)               | If Under 1 Year<br>Months Days               | If Under £4 Hr<br>Hours Mir | S. 8. Date of 8    | irth            | 9. Birthi                   | place (State or Foreign                          |
| W                               | Director  |                           | 219-36-6861   | 1 <b>X</b> M 2□F            | 66                                   | Yrs.                        | Months Days                                  | Hours Will                  | 09/06/             | 1939            | 000                         | MD   |
| ~                               | D .   |                           | Usual Residence of Decedent  10a, State 10b, County   |                             | 100 Cib                              | , Town or Lo                | agation                                      |                             |                    |                 |                             | I Od. Inside City Limits                         |
| 2                               | arylan<br>ehow  | -                         |   |                             |                                      |                             |  |                             |                    |                 |                             | 1 XYes 2 □ No                                    |
| R                               | s 1 and 2 should be filed within 72 hours after death with the Maryland I Health and Mental Hygiene. Item 27 is marked other than "natural", or Itema 23a or 28a-f show other traumatic event. It a Madical Examinational be notified at  | Director                  | MD Worcest  10e, Street and Number  | er                          | Sno                                  | ow Hil                      | 10f. Zip Code                                |                             |                    | 100 Citiz       | en of What Cou              |  |
| #                               | with t  |                           | 331 E. Market   | Ctuant                      |                                      |                             |  |                             |                    |                 |                             | muy:   |
| 53                              | after death w<br>or Itema 23a   | Funerai                   | 11. Marital Status  |                             | edent Ever in U.                     | S. 13.                      | 21863<br>Was Decedent of His                 | spanic Origin?              | Specify Yes or N   | US<br>lo-       | A<br>4. Race - Ameri        | can Indian,                                      |
|                                 | lter d  | 'n                        | 1 Never Married Married   | Armed Fo                    | rces?                                | }                           | Was Decedent of His<br>If Yes, specify Cubar | , Mexican, Pue              | rto Rican, etc.)   |                 | Black, White,               |  |
| 38                              | urs a   | by                        | 3 Widowed 4 Divorced  | If Yes, Giv<br>Year or D    | /e                                   |                             | 1□Yes XXNo                                   | Specify:                    |                    |                 | Specity: Wh                 | ite  |
| 21215-0036                      | within 72 hours after<br>ene.<br>then "netural", or Ite   | Completed                 | 15. Decedent's (Specify only highest of   |                             |                                      | 16a. Dece                   | dent's Usual Occupa<br>kind of work done d   | tion                        | orkina             | 16b. Kin        | d of Business/In            | dustry   |
| 2 2                             | within 7<br>ene.<br>than "r   | nple                      | Elementary/Secondary (0-12)   | College (1                  | -4or 5+)                             | life.                       | DO NOT use retired)                          | anng moon on m              | Jg                 |                 |                             |  |
| رہ<br>10ء                       | ed wi   | S                         | 12  |                             |                                      | Farn                        |  | 40.14 1.11                  |                    |                 | rming                       |  |
| ک<br>اnd                        | be fill H d oth   | Be                        | 17. Father's Name (First, Middle, La  |                             | _                                    |                             |  |                             | ame (First, Midd   |                 | Sumame)                     |  |
| A ⊳ (s                          | 2 should be filed v<br>n and Mental Hygie<br>is marked other<br>raumatic event. It  | ၉                         | William Thomas  |                             | <u>n</u>                             | 10h Maili                   | ng Address (Street a                         |                             | ude Dry            |                 | Tour State 7in              | Codo)  |
| Mai                             | 12 st<br>h and<br>7 is n<br>traun   | 8                         | 19a. Informant's Name/Relationship  Ann Robinson  |                             |                                      |                             | E. Marke                                     |                             |                    |                 |                             |  |
| TT 0                            | of Health<br>Item 27 I  |                           | 20a. Method of Disposition  | (WITE)                      | 20b. P                               |                             | sition (Name of                              | st Stree                    | Date               | _               | cation - City or To         |  |
| altimore                        | permit. Pages<br>Department of I<br>Important: If It<br>any Injury or o   |                           | 1 Burial 2 Cremation 3  |                             | State                                | emetery, cre                | matory or other place                        | 1                           |                    |                 | -51 00                      |  |
| bert                            | artme<br>ortani<br>injury   |                           | 4 Donation 5 Dother (Special Signature of Funeral Service Lice  |                             | Spi                                  | ring H                      | III Cemete                                   | ery 12/                     | 12/2005            | Gird            | letree,                     | MD   |
| Ba                              | permi<br>Depa<br>Impo<br>any I  |                           | 21.50   | JA AL                       | mil.                                 |                             | 2. Name and Addres                           |                             |                    |                 |                             |  |
| 4                               |   |                           | 23a. Part1. Enter the disease, or co<br>shock, or heart failure. List or                                    | piplications that           | aused the deat                       |                             |  |                             |                    |                 | עואו , ווו                  | Approximate                                      |
|                                 | Discolation   |                           | Immediate Cause (Final  | fy one cause on t           | ach line.                            | 21/11                       | H321   |                             | 11500              | 260             |                             | Interval Between<br>Onset and Death              |
|                                 | Physician /Medical  |                           | disease or condition resulting in death)  | a. Due to                   | (or as a conseq                      | uence of):                  | 11201  | 8                           |                    | 2 )12           |                             | year 5   |
|                                 | Examiner  |                           | Managarana (Supplemental)   | 50010                       | (0. 20 2 00.1004                     | .,.                         |  |                             |                    |                 |                             |  |
|                                 |   | ē                         | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | Due to                      | (or as a conseq                      | uence of):                  |  |                             |                    |                 |                             |  |
|                                 | be executed<br>sician and<br>burial-transit   | Examiner                  | that initiated events   | c.                          |                                      |                             |  |                             |                    |                 |                             |  |
| ó                               | ate be executed<br>hysician and<br>the burial-transit   |                           | resulting in death) Last  | Due to                      | (or as a conseq                      | uence of):                  |  |                             |                    |                 |                             |  |
| 8760,                           | ate be<br>hysici<br>the bu  | dical                     |   | d                           |                                      |                             |  |                             |                    |                 |                             |  |
| 39                              | artifica<br>ing pt  | Med                       | IF FEMALE:  |                             |                                      |                             |  |                             |                    |                 |                             |  |
| Box 6                           | that the death certifi<br>ed by the attending<br>detached for use as  | Completed by Physician/Me | 23b. Was decedent pregnant in the past 12 months?   | 1 ☐ Live t                  | tcome of pregna<br>pirth 2 ☐ Feta    | I death 3                   | Ectopic pregnancy                            |                             |                    | 2               | 3d. Date of delive<br>Month | ery<br>Day Year                                  |
|                                 | e des<br>the a  | Sici                      | 1 Yes 2 No  | 4∐Pregr<br>9⊡Unkn           | nant at time of d<br>own             | eath 5[                     | Other (specify)                              |                             |                    |                 |                             | ,  |
| Division of Vital Records, P.O. | hat the d by  | F.                        | Part II. Other significant condition  | contributing to d           | eath but not res                     | ulting in the u             | nderlying cause give                         | n in Part I.                | 23e. Dio           | tobacco us      | se contribute to t          | he cause of death?                               |
| S,                              | w requires that<br>s been signed t<br>s should be det   | b                         | 1.12110   | CA                          | NCE                                  | -P_                         |  |                             |                    | Yes 2           |                             | /  |
| Ö                               | requ  | etec                      | 7   |                             |                                      |                             |  |                             | 24a. Wa            |                 | Odb Wass subs               | tindings and lable                               |
| ec<br>Sec                       | e taw<br>has t  | E E                       |   |                             |                                      |                             |  |                             | aut                | opsy<br>formed2 | prior to co                 | opsy findings available<br>impletion of cause of |
| <u>=</u>                        | ician: The tree certificate ha  |                           |   |                             |                                      |                             |  |                             | 1 ☐ Yes            | 2 🗷 No          | 1 🗌 Yes                     | 2 No   |
| <u> </u>                        | ysician:<br>is certific<br>director,  | Be                        | 25. Was case referred to medical examiner?  | Hospital:                   |                                      | 5510                        | ot all DOA Othe                              | Ar-                         | eath (Check only   |                 |                             |  |
| of                              | Phys<br>ral di  | 5 T                       | 1 ☐ Yes 2 ② No  27. Manner of Death   |                             | Inpatient 2  of Injury th, Day Year) | ER/Outpatie<br>28b. Time of | 3C1 DOX                                      | 4 🗀 (40) 31(19              | Home 5 ☐ Re        |                 |                             | (y)  |
| u <sub>o</sub>                  | ding Ph<br>h.<br>After th<br>funeral  | tion                      | 1 ☑Natural 5 ☐ Pending<br>2 ☐ Accident investiga  |                             | th, Day Year)                        | Injury                      |  | ?<br>∕es 2 □No              |                    |                 |                             |  |
| <u>is</u> :                     | Attend<br>death<br>ctor:<br>y the   | fica                      | 3 ☐ Suicide 6 ☐ Could no  |                             | of Injury - At h                     | ome, farm, st               | reet, factory, office                        |                             | 28f. Location      | (Street and     | Number or Run               | al Route Number,                                 |
| á                               | affer affer d in b  | Certification:            | 4 Homicide  | build                       | ing, etc. ( <i>Specit</i>            | y)                          |  |                             | City or I          | own, State)     |                             |  |
|                                 | To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending p completely filled in by the funeral director, page 2 should be detached for use as |                           | 29a. Certifier 1 Certifying   | Physician: To the           | best of my kno                       | wledge, deal                | h occurred at the tim                        | e, date and pla             | ce, and due to th  | e cause(s)      | and manner as s             | stated.  |
|                                 | n 24 l<br>n 24 l<br>ne Fu<br>yletely  | edicai                    | (Check only 2 Medical Ex  | aminer: On the b<br>and man | easis of examina<br>iner stated.     | uon and/or ir               | vestigation, in my op                        | oinion, death oc            | curred at the time | e, date and     | piace, and due t            | o ine cause(s)                                   |
|                                 | To the To the Comp  | Σ                         | 29b. Signature and tille of certifier   | 10 100                      | 0                                    |                             | 29c. License                                 | number                      | 2                  | 29d. Date       | signed (Month,              | Day, Year)                                       |
|                                 |   | 8                         | - foldell   | 7 1                         | 74                                   | 7                           | 100  | 160                         | 2                  | 12              | -/8/                        | 05   |
| /                               | _   |                           | 30. Name and address of person with   | o completed                 | se of death (Item                    | n 23a) (Туре                | Print)                                       | 501                         | (=  -              |                 | N A                         | 0 2:00   |
| ~                               | TO  |                           | 145 725   | 1 (2                        | IVYOI                                |                             | 77.  | 001                         | ロカレ                | ru              | 100                         | 11 61001   |

State Registrar

31. Date filed (Month, Day, Year)
DEC 1 2 2005

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3. Time of Death **Physician** Elizabeth Virginia Rizk 2005 Dec. 06:15 P<sup>M</sup> /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Homewood Retirement Center Williamsport Washington 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 03/31/1917 Birthplace (State or Foreign Country) **Funeral** Days Hours 1 ☐ M 2 🛣 F 212-38-8689 88 Yrs. Director MD Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. int: If item 27 is marked other than "nature!", or items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "naturel", or items 23a or 28a-f show other traumatic event, the Modical Example in an intermitative rolling at Director MD Washington Williamsport 1 ☐ Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21795 16505 Virginia Avenue US Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1ÆJYes 2 □ No If Yes, Give Year or Dates: 1940–61 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 21 No Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Nurse US Military 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Daniel Strobel Schnebly Carrie Edith Curfman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other training. William P. Young, Jr./Pers.Rep. 82 W. Washington Street, Hagerstown, MD 21740 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 12/15/05 4 ☐ Donation 5 ☐ Other (Specify) Rest Haven Cemetery Hagerstown, MD 21. Signature of Funeral Service Ligensee 22. Name and Address of Facility Gerald N. Minnich Funeral Home 305 N. Potomac Street, Hagerstown, MD 21740 23a. Part1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line. mode of dying, such as cardiac or respiratory arrest, mmediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a co Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy Month Day 4☐Pregnant at time of death 5 Other (specify) ed by the a detached f 9□ Unknown 9 Unknow s been signed by should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 1 Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy 20 1□ Yes After this certification funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only on Hospital: Other: Medical Certification: To 1 Tes 2 No 1 🗌 Inpatient 2 ER/Outpatient 4 Nursing Home 5 Residence 6 Other (Specify) 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manger of Death 28b. Time of Injury 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending death. investigation 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funerel Director: / completely filled in by the fi 6 Could not be 3 ☐ Suicide Płace of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 - Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated 29b. Signatu 29c. Licagse numbe 29d. Date signed (Month, Day, Year) DH-10+1 31. Date filed (Month 32. Registrar's Signature State Registrar

Louisa Ann Reynolds 05-08194 NJM

|                   |   |                | For<br>State<br>Registrar  | State of                                      | of Marylan   |                                 | artment of F<br>tificate of a               |                                      | d Mental Hy                               | /giene<br>Reg. No.       | 005                               | 41623   |
|-------------------|---|----------------|--|---|--|---------------------------------|---|--------------------------------------|---|--------------------------|-----------------------------------|---|
|                   | Physici   | an             | 1. Decedent's Name (First, Midd  | lle, Last)                                    |  |                                 |   |                                      | 2. Date of D<br>Month                     | eath<br>Day              | Year                              | 3. Time of Death                                |
|                   | /Medic  |                | LOUISA   | ANN   |  | YNOLDS                          |   |                                      | Decemb                                    | er 5                     | 2005                              | 0418 <sup>M</sup>                               |
| 1                 | Examin  | er             | 4a. Facility Name (If not institution 2700 Block Lo                          | -   |  |                                 | 4b. City, Town, or I jamsv                  |                                      | ath                                       |                          | ederick                           |   |
|                   | Funeral   |                | 5. Social Security Number  | 6. Sex  | 7. Age (In yrs.                                      | last birthday)                  | If Under 1 Year                             | If Under 24 H                        | rs. 8. Date of B                          | irth                     | 9. Birtho                         | lace (State or Foreign                          |
| п                 | Director  |                | 212-23-6089  | 1□M 2∏F                                       | 1  | 7 Yrs.                          | Months Days                                 | Hours M                              | in. (Month, D<br>NOV . 4                  |                          | Mary                              |   |
|                   | Du B  |                | Usual Residence of Decedent  10a, State 10b, Count                           | v   | 10c. Cit   | y, Town or Lo                   | cation                                      |                                      |   |                          | 1                                 | Od. Inside City Limits                          |
|                   | daryla<br>f eho   | 20             |  | rederick                                      |  | Ijams                           |   |                                      |   |                          | +                                 | 1 ☐ Yes 2X No                                   |
|                   | 28a-  | Director       | 10e. Street and Number   | rederick                                      | 1  | rjams,                          | 10f. Zip Code                               |                                      |   | 10g. Citizer             | n of What Cour                    | ntry?   |
|                   | th with   | ai D           | 11295 Wood   | dhaven Dr                                     | ive  |                                 | 217   | 54                                   |   | Unite                    | d Stai                            | tes   |
|                   | - deal  | Funerai        | 11. Marital Slatus   | 12. Was Dec<br>Armed F                        | cedent Ever in U.<br>orces?                          |                                 | Was Decedent of H                           | ispanic Origin?<br>In, Mexican, Pu   | (Specify Yes or Nerto Rican, etc.)        | 0- 14.                   | Race - Americ<br>Black, White,    |   |
| 36                | hours after death with the Maryland<br>turel', or Iteme 23a or 28a-f ehow<br>at Examinationat be notified at  | by Fu          | 1 Never Married 2 Ma<br>3 Widowed 4 Divorce                                  | If Yas G                                      | 2 X No<br>ive  |                                 | I□Yes 2X No                                 | Specify:                             |   | Sp                       | pecity: Whi                       |   |
| ခို               | 2 hour  | edt            | 15. Decede   | ent's Education                               |  | 16a. Deced                      | ient's Usual Occup                          | ation                                |   | 16b. Kind                | of Business/Inc                   | dustry  |
| 21215-003         | hin 73  | pie            | (Specify only high<br>Elementary/Secondary (0-12)                            | est grade completed) College (                | )<br>(1-4or 5+)                                      | (Give<br>life. L                | kind of work done of<br>OO NOT use retired  | during most of v<br>1)               | vorking                                   |                          |                                   |   |
|                   | be filed within 72 hours after death with the Marylan itel Hygiene. ad other than "naturel; or iteme 23a or 28a-1 show event, the Madical Examinar count be notified at | Completed      | 12   |   |  | St                              | tudent                                      |                                      |   |                          |                                   | Student   |
| Maryland          | be fill<br>H of oth   | Be             | 17. Father's Name (First, Middle Robert                                      | v, Last)<br>W •                               | Darma 1  | 1 1 -                           |   |                                      | iame (First, Middle                       |                          |                                   |   |
| <u> </u>          | s 1 and 2 should be if Health and Mentel I Item 27 is marked o other treumatic eve  | ို             | 19a. Informant's Name/Relation   |   | Reynol   |                                 | g Address (Street                           | Katr<br>and Number or                |   |                          | edahl<br>own State Zio            | Code)   |
|                   | nd 2 shoulth and 27 is my r troums  |                | Robert W. Reyno  |   | her  |                                 | Woodhav                                     |                                      |   |                          |                                   | ,   |
| Ē,                | item 27 i   |                | 20a. Method of Disposition   | - 0-  |  | face of Dispo                   | sition (Name of<br>natory or other place    |                                      | Date                                      |                          | ion - City or To                  |   |
| altimore,         | Pages<br>nent of<br>ant: If its<br>ury or o   |                | 1 🖾 Burial 2 □ Cremation<br>4 □ Donation 5 □ Other (                         |   | 1 State  | * '                             | ivet Cem.                                   | · 1                                  | 10/2005                                   | Frede                    | rick, N                           | laryland  |
| Balt              | permit. Pages 1<br>Depertment of H<br>Important: If ite<br>eny injury or ott  |                | 21. Signature of Funeral Service   | Licensee                                      | 2 cera   | ) .                             | Name and Address 621 Oposs                  |                                      |   |                          |                                   | s, P. A.<br>21702                               |
|                   |   |                | 23a. Part1. Finer the disease, of shock or heart failure. Lis                | or complications that<br>st only one cause on | caused the death                                     | h. Do not ent                   | er the mode of dyin                         | g, such as card                      | iac or respiratory                        | arrest,                  |                                   | Approximate<br>Interval Between                 |
| ė,                | Physician   |                | Immediate Cause (Final disease or condition                                  | . /   | Asphyx   | 11a 6                           | y hang                                      | 165                                  |   |                          |                                   | Onset and Death                                 |
|                   | /Medical<br>Examiner  |                | resulting in death)  | Due to  | (or as a consequence                                 | uence of):                      |   |                                      |   |                          |                                   |   |
|                   |   | 9.             | Sequentially list conditions, if any, leading to immediate                   | b. — Due tu                                   | (ur as a consequ                                     | uarice of).                     |   |                                      |   |                          |                                   |   |
|                   | uted<br>d<br>ansit  | Examiner       | cause. Enter Underlying<br>Cause (Disease or injury<br>that initiated events | <b>{</b>                                      |  | ,                               |   |                                      |   |                          |                                   |   |
| ó                 | exec<br>en en   | Еха            | resulting in death) Last   | Due to  | (or as a consequ                                     | uence of):                      |   |                                      |   |                          |                                   |   |
| 8760              | cate be executed<br>physicien end<br>the burial-transit   | dicai          |  | d   |  |                                 |   |                                      |   |                          |                                   |   |
| 9                 | ding p  | /Mec           | IF FEMALE:   | 23c If yes o                                  | atcome of pregna                                     | incv                            |   |                                      |   |                          | D-44-1-E-                         |   |
| Box               | death certifi.<br>e ettending p<br>id for use as  | cian/Me        | 23b. Was decedent pregnant in the past 12 months?                            | 1 ☐ Live                                      | birth 2 Fetal  | Ideath 3                        | Ectopic pregnancy Other (specify)           |                                      |   | 23d                      | I. Date of delive<br>Month        | Day Year  |
| o.                | 0 0   | Physic         | 1 □ Yes 2 □ No<br>9 Unknown  | 9□ Unkr                                       |  |                                 |   |                                      |   |                          |                                   |   |
| ď.                | The law requires that the site has been signed by the bege 2 should be detached.  | by PI          | Part II. Other significant condit  | tions contributing to c                       | death but not resi                                   | ulting in the ur                | nderlying cause giv                         | en in Part I.                        | 23e. Did                                  | tobacco use              | contribute to th                  | e cause of death?                               |
| Records,          | w require<br>been sig<br>should b   |                |  |   |  |                                 |   |                                      | - 10                                      | Yes 2001                 | lo 3□Prob                         | ably 4 □Unknown                                 |
| မင္ပ              | e lawr<br>hes be  | Completed      |  |   |  |                                 |   |                                      | 24a. Was                                  | psy                      | 4b. Were auto                     | psy findings available<br>appletion of cause of |
| <u> </u>          |   | Con            |  |   |  |                                 |   |                                      | 1)X Yes                                   | ormed?<br>2 ☐ No         | Yes                               | 2□ No   |
| <u> </u>          | Attending Physicien: The research.  ector: Atter this certificate by the funeral director, per  | Be             | 25. Was case referred to medic examiner?                                     | Hospital:                                     | 11   | 50.0                            | t all poal Oth                              | 05                                   | Death Check only                          |                          |                                   |   |
| Division of Vital | g Physical dispersal di   | ٦: <u>٦</u>    | XXYes 2 □ No<br>27. Manner of Death  | 28a. Date                                     | of Injury  | ER/Outpatien<br>28b. Time of    | t 3 DOA 28c. Injur                          | 4   140131119                        | Home 5 ☐ Res<br>28d. Describe             |                          |                                   | ) Scene   |
| o                 | ath.<br>r: After<br>e funer   | atio           | 1 □Natural 5 □ Pend<br>2 □ Accident inves                                    | tigation Full I                               | nth, Day Year)                                       | Injury<br>Frank 1 4:1           |   | Yes 2 No                             | Subject                                   | + hour                   | sed se                            | 4   |
| <u>N</u>          | or Attendetter desti<br>Director:   | Certification: | 3 Suicide 6 ☐ Could<br>4 ☐ Homicide deter                                    | mined 200. Flat                               | e of Injury - At ho                                  | ome, farm, str                  | eet, factory, office                        |                                      | 28f. Location<br>City or To               | (Street and Nown, State) | umber or Rura                     | l Route Number,                                 |
|                   | ital or A<br>irs efter<br>rai Dire  |                |  |   |  | WOGH                            |   |                                      | 2700 Blow                                 | Lock                     |                                   | Frederick, M)                                   |
|                   | Hospita<br>24 hours<br>Funeral<br>etely filled  | edical         | 29a. Certifier 1 Certify (Cireck only 22K Medica                             | ing Physician: To the card man                | e best of my kno<br>basis of examina<br>nner stated. | wiedge, death<br>tion and/or in | occurred at the ting<br>estigation, in my o | ne, date and pla<br>pinion, death oc | ice, and due to the<br>corred at the time | cause(s) and pla         | d manner as st<br>ace, and due to | ated.<br>the cause(s)                           |
|                   | To the Hospital or At within 24 hours effer of To the Funeral Direct completely filled in by  | Med            | 29b. Signature and title of certification                                    |   | o. stated.   |                                 | 29c. Licens                                 | e number                             |   | 29d. Date s              | igned (Month,                     | Day, Year)                                      |
|                   | ~ > P 0   |                | > Zhu  | 18 4  | 1e -   | `                               | OCI   | ΜE                                   |   | Decen                    | mber, 5                           | , 2005  |
|                   | 2   |                | 30. Name and address of perso  | n who completed cau                           | ise of death (Item                                   | п 23а) (Туре,                   |   | _                                    |   |                          |                                   |   |
|                   |   |                | CATT (L)   | CVYH  | 15   |                                 |   | enn Stre                             | eet Balt                                  | imore,                   | , Maryla                          | and 21201                                       |
|                   | Sta<br>Registi  |                | 31. Date filed (Month DEC 1  | 2 2005  | gistrar's Signa                                      | A A                             | parle                                       |                                      |   |                          |                                   |   |

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** DECEMBER 7, 2005 JOHN ROOD. ALSON 1:15 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 12 BEXHILL COURT CHARLES WALDORF If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number Sex M 2□F 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Jan. 19 Birthplace (State or Foreign Country) **Funeral** 270-32-3149 69 1936 Ohio Director Usual Residence of Decedent the Maryland 10a. State 10c. City. Town or Location 10b. County 10d. Inside City Limits orient: If item 27 is marked other then "natural", or items 23a or 28e-f show injury or other treumstic event, the Madical Examinar must be notified at 1 ☐ Yes 2 🗓 No Director Maryland Charles Waldorf 10g. Citizen of What Country? 10e. Street and Number permit. Pages 1 and 2 should be filed within 72 hours after deeth with t Department of Health and Mental Hygiene.
Importent: If Item 27 is marked other than "natural", or items 23a or 2 any injury or other treumatic event, the Madical Experience. 10f. Zip Code 12 Bexhill Court 20602 U.S.A. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No 195 If Yes, Give Year or Dates: 197 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1955-1 Never Married 2 XMarried Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify. 1975 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Police Officer U.S. Capitol Police 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be John Henry Rood ဂ္ Marie Korn 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bexhill Court, Waldorf, Maryland, 20602 Sharon D. Rood/Spouse 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 Burial 2 Cremation 3 Removal from State 4 Donarion 5 Other (Specify) ° 4 ☐ Donation 12-08-2005 Huntt Crematory Waldorf, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility M00053 P.O. Box 156 УΛ Huntt Funeral Home Waldorf, Maryland 20604 23a. Part I Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequent Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) The law requires that the death certificate be executed use as the burial-transit resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? 4☐Pregnant at time of death
9☐Unknown Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No detached the 9 Unknown signed by ti Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Medical Certification: To Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No page 2 autopsy certificate 1 ☐ Yes or Attending Physicien: the funeral director, 25. Was case examiner? eferred to medical 26. Place of Death (Check only one) Hospital: Other: 4 \( \sum \) Nursing Home 2 No 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 ☐Other (Specify) this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? lanner of Death 28b. Time of 28d. Describe how injury occurred After 5 Pending investigation Natural after death. 1 ☐ Yes 2 ☐ No 2 Accident 3 🗌 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide within 24 hours To the Funerel Tell Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and the of certifier Made 0 DECEMBER 7, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DANIEL M. HOWELL, MD, 1 R 1/3 11345 PEMBROOKE SQ., #104, WALDORF, MD 20603 31. Date filed (Month, Day, Year) 32. Redistrar's Signature State

DHMH 17 Rev 1/2001

Registrar

DEC 0 9 2005

March Service

|  |  |                  | 1 - For<br>State<br>Registrar  | State of M  | laryland / Dep<br><i>Ce</i>                                     | artment of<br><i>rtificate of</i>                       |   |   | giene                      | 5 41625   |  |  |  |  |
|--|--|------------------|--|---|---|---|---|---|----------------------------|---|--|--|--|--|
|  | Physici<br>/Medi   |                  | 1. Decedent's Name (First, Middle, Las   | 11)<br>455(ea   | <u> </u>  |   |   | 2. Date of De<br>Month                  | th Day Year                |   |  |  |  |  |
|  | Examir   |                  | 4a. Facility Name (If not institution, give<br>Howard County Ger   | neral Hos   | pital   | Colu  |   |   | 4c. County                 | of Death<br>ward  |  |  |  |  |
|  | Funeral<br>Director  |                  | 5. Social Security Number 6. Security Number 6. Security Number 11 11 11 11 11 11 11 11 11 11 11 11 11   | 9X 7. A<br>M 2 F  | Age (In yrs. last birthday, 55 Yrs.                             | If Under 1 Yea<br>Months Days                           |   | n. July 28                              | 3, 1950                    | 9. Birthplace (State or Foreign<br>Country)<br>North Carolina           |  |  |  |  |
|  | e Maryland<br>Ba-f show  | ctor             | MD Howard  | L   | 10c. City, Town or L  |   |   |   |                            | 10d. Inside City Limits 1 ☐ Yes 2 No                                    |  |  |  |  |
|  | ath with the 23s or 2  | Funeral Director | 10e. Street and Number<br>4790-9 Dorsey Hal  | l Drive   |   | 10f. Zip Code 210                                       | 42  |   | 10g. Citizen of W          | that Country?<br>d States   |  |  |  |  |
| 9036   | ours after de<br>ral', or Items<br>Era di er n   | by               | 11. Marital Status  1 □ Never Married 2 ☑ Married  3 □ Widowed 4 □ Divorced  | 12. Was Deceden Armed Forces 1  Yes 2 If Yes, Give Year or Dates  | 5?<br><b>X</b> No   | Was Decedent of<br>If Yes, specify Cu<br>1 ☐ Yes 2 ██No |   | (Specify Yes or No<br>arto Rican, etc.) | Specify:                   | o-American Indian,<br>k, White, etc.<br>White                           |  |  |  |  |
| 21215-0036   | s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene, item 27 is marked other than "natural", or Items 23s or 28s-1 show other traumatic event, the Medical Eventral Fermatic | Completed        | 15. Decedent's Ed<br>(Specify only highest grad<br>Elementary/Secondary (0-12)   | ucation<br>de <i>completed)</i><br>College (1-4or<br><b>3</b>   | (Give<br>life.  |   | upation<br>e during most of w<br>ed) Superv<br>ems Anal |   | 16b. Kind of Bu            | siness/Industry   |  |  |  |  |
| Maryland 2   | 2 should be filed withir<br>and Mental Hygiene<br>Is marked other than<br>aumatic event, the Mi  | To Be C          | 17. Father's Name (First, Middle, Last) Alexander S. Rugg  |   | -   |   | 18. Mother's N<br>Ruth Ja                               | ame (First, Middle,                     | ,                          |   |  |  |  |  |
|  | 1 and 2 shy<br>Health and<br>tem 27 is m   | 1 5              | 19a. Informant's Name/Relationship (7 Gail P. Ruggiero/  |   | 4790  | -9 Dorse  |   |   | i∞tt Cit                   | ty, MD 21042  |  |  |  |  |
| Baltimore,   | Page<br>nent o<br>ant: If<br>ury or  |                  | 1 ☐ Burial 2 🗷 Cremation 3 ☐  `4 ☐ Donation 5 ☐ Other (Specify)  | Sethod of Disposition   20b. Place of Disposition (Name of cametery, crematory or other place)   Date   20c. Location · City or Town, State |   |   |   |   |                            |   |  |  |  |  |
| Ba   | permit. Departr Imports any inju   |                  | 23a. Part 1. Enter the disease, or comp  | olications that cause   | ded the death. Do not ent                                       | 112 Old   | Columbia  | Pike Ell                                | Licott C                   |   |  |  |  |  |
|  | Physician<br>/Medical<br>Examiner  |                  | Immediate Cause (Final disease or condition resulting in death)  | a   | Ine.  Myocare s a consequence of):                              |   | 020   |   | 7                          | Interval Between<br>Onset and Death<br>(2 h cms                         |  |  |  |  |
| 68760,   | icate be executed<br>physician and<br>s the burial-transit   | edicai Examiner  | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | c   | s a consequence of): s a consequence of):                       |   |   |   |                            |   |  |  |  |  |
| .O. Box 68   | The law requires that the death certifica<br>te has been signed by the attending ph<br>age 2 should be detached for use as t   | Physician/Med    | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  |   | 2 Fetal death 3   | Ectopic pregnanc<br>Other (specify)                     | ÿ   |   | 23d. Date<br>Mont          | of delivery<br>th Day Year  |  |  |  |  |
| <b>Q</b>   | w requires that the bound by should be detact  | by               | Part II. Other significant conditions co   | ntributing to death   | but not resulting in the u                                      | nderlying cause g                                       | ven in Part I.  | Til .                                   |                            | oute to the cause of death?  B Probably 4 Unknown                       |  |  |  |  |
| Vital Records,   |  | e Completed      | 25. Was case referred to medical   | gran  |   |   |   |   | sy pr<br>med? de<br>2 No 1 | ere autopsy findings available<br>for to completion of cause of<br>ath? |  |  |  |  |
| 1   Inpatient 2   ER/Outpatient 3   DOA   4   Nursing Home 5   Residence 6   O |  |                  |  |   |   |   |   | ence 6 Other                            |                            |   |  |  |  |  |
| Division   |  | Certification;   | 3 Suicide 6 Could not be<br>4 Homicide determined  | building, e   | njury - At home, farm, str<br>tc. (Specify)                     |   |   | City or Tow                             | n, State)                  | r or Rural Route Number,  |  |  |  |  |
|  | To the Hospital or within 24 hours after To the Funeral Director completely filled in E  | Medical          | 29a. Certifier (Check only one)  1 □ Certifying Phy 2 □ Medical Exami  | rsician: To the best<br>iner: On the basis of<br>and manner s   | t of my knowledge, death<br>of examination and/or in-<br>tated. | occurred at the ti<br>restigation, in my a              | opinion, death occ                                      | urred at the time, d                    | late and place, an         | d due to the cause(s)   |  |  |  |  |
|  |  | 1                | 30. Name and address of person who   | _ MO  | (NHEVA)   |   |   | 3                                       | ecenh                      | (Month, Day, Year)  5 9, 2005  61-4912  (my/M026-2)                     |  |  |  |  |
| (J)  | Sta  | te               | 31. Date filed (Month, Day, Year)  | onger   | MD = 205  | ((05)   | Little  | a Poty                                  | centre                     | Kuy MD 20-10  |  |  |  |  |
|  | Registr  | _                | DEC 1 2 2  | .005  | rar's Signature   | barles  |   |   |                            | 1   |  |  |  |  |

|            |  |                  | Please T  1 - State Registrar  | ype or Print in<br>State of Maryla   | ind / Depa                           |  | dealth and                           | -   |                          | 005  | 41626   |
|------------|--|------------------|--|--|--------------------------------------|--|--------------------------------------|---|--------------------------|--|---|
|            | Physici  | an               | 1. Decedent's Name (First, Middle, Last)   |  |                                      |  |                                      | 2. Date of Do                             | <u>·</u>                 | -  | 3. Time of Death                              |
|            | /Medio   | cal              |  | ul A. Schule   | r, 0.S.                              |  |                                      | Decemb                                    | er 1                     | 5 2005   | 0555 A <sup>M</sup>                           |
|            | Examir   | ner              | 4a. Facility Name (If not institution, give standard Hall  5. Social Security Number 6. S |  | s. last birthday)                    | 4b. City, Town, of Childs  If Under 1 Year                   |                                      |   |                          | Cecil  | place (State or Foreig                        |
|            | Funeral<br>Director  |                  |  | IM 2□F 64  | Yrs.                                 | Months Days  |                                      | in. 8. Date of Bi<br>(Month, Di<br>NOV 8, | 1941                     | 1 New  | Jersey  |
|            | s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other then "neturel", or Items 23a or 28e-f show other treumatic event, The Maryland Examilinar must be realified at | Director         | 10a. State 10b. County  Maryland Cecil  10e. Street and Number   |  | City, Town or Lo                     | 10f. Zip Code  |                                      |   | 10g. Citi                | izen of What Co                                | 10d. Inside City Limits 1 ☐ Yes 2 ☐ No untry? |
|            | 23a c  | al               | 1120 Blue Ball R   | oad  |                                      | 21916  |                                      |   | Un                       | ited Sta                                       | ates  |
| 920        | urs after dea<br>el', or Items<br>Examinario   | by Funeral       | 11. Marital Status  1 1 Never Married 2  Married 3  Widowed 4 □ Divorced   | 12. Was Decedent Ever in<br>Armed Forces?<br>1  Yes 2  No<br>If Yes, Give<br>Year or Dates:    |                                      | Was Decedent of H<br>If Yes, specify Cub<br>1 ☐ Yes 2 ☐ No   |                                      | (Specify Yes or No<br>erto Rican, etc.)   |                          | 14. Race - Amer<br>Black, White<br>Specify: Wh |   |
| 21215-0036 | thin 72 ho<br>e.<br>en "netur  | Completed        | 15. Decedent's Edu<br>(Specify only highest grade<br>Elementary/Secondary (0-12)   |  | (Give                                | dent's Usual Occup<br>kind of work done<br>DO NOT use retire | during most of v<br>d)               |   | 16b. Kii                 | ind of Business/l                              |   |
| 2          | filed withi<br>Hygiene.<br>other then<br>ent, the M  |                  |  | 2  | Di                                   | rector of  |                                      |   |                          | ligious  | <u>Order</u>                                  |
| Maryland   | 12 should be filed within "<br>h and Mental Hygiene.<br>7 is marked other then "<br>reumatic event, the Mac  | To Be            | 17. Father's Name (First, Middle, Last) Walter P. Schule:  | r  |                                      |  |                                      | lame <i>(First, Middle</i><br>L Champou   |                          | Sumame)  |   |
| lan,       | 2 sho<br>and l   | ľ                | 19a. Informant's Name/Relationship (Ty   | ·  |                                      |  |                                      | Rural Route Numb                          |                          |  |   |
|            | s 1 and 2<br>of Health<br>item 27 l  |                  | Oblates of St. Fran  |  |                                      | Kentmere   |                                      |   |                          |  | are 19806                                     |
| Baltimore, | Page<br>ment o<br>ant: If<br>ury or  |                  | 1 ☐ Burial 2 🕅 Cremation 3 ☐ R<br>`4 ☐ Donation 5 ☐ Other (Specify)  | emoval from State  | cometery, crer<br>A. Ferris          | s & Co. Inc  | . 15,                                | ember<br>2005                             | Wes                      | st Chest<br>nnsylvan                           | er,   |
| Balt       | permit. Pag<br>Department<br>Importent: I<br>any injury o  |                  | 21. Signature of Funeral Service License   | 2 - Li. B  | ) 122<br>H-<br>10                    | Name and Addre   | ss of Facility for Fu                | nerals,                                   |                          |  | and 21921                                     |
|            | Physician<br>/Medical<br>Examiner  |                  | 23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)  | cations that caused the dele cause on each line.  Due to (or as a conse                        | Struct                               | er the mode of dyir  | ng, such as card                     | iac or respiratory a                      | irrest,                  |  | Approximate Interval Between Onset and Death  |
| 1          | uted<br>d<br>ansit   | Examiner         | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events  | Due to (or as a conse  | equence of):                         |  |                                      |   |                          |  |   |
| 68760,     | ate be executed<br>hysicien and<br>the burial-transit  | -                | resulting in death) Last   | Due to (or as a conse  | equence of):                         |  |                                      |   |                          |  |   |
| .O. Box 6  | that the death certificate be<br>ed by the attending physicie<br>detached for use as the bur   | Physician/Medica | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  | 3c. If yes, outcome of preg<br>1 □ Live birth 2 □ Fe<br>4 □ Pregnant at time of<br>9 □ Unknown | ital death 3                         | Ectopic pregnancy Other (specify)                            | ,                                    |   | 2                        | 23d. Date of deliv<br>Month                    | ery<br>Day Year                               |
| rds, P.    | quires that<br>in signed build be deta   | by               | Part II. Dther significant conditions cor  | tributing to death but not re  | esulting in the ur                   | nderlying cause giv  | en in Part I.                        | 23e. Did t                                | /                        |  | the cause of death?                           |
| I Records, | The law requires that the rate has been signed by the page 2 should be detache   | Completed        |  |  |                                      |  |                                      | 24a. Was<br>auto<br>perfo                 |                          | prior to co                                    | opsy findings available ompletion of cause of |
| Vital      | Physicien:<br>r this certifica<br>ral director, I  | Be               | 25. Was case referred to medical examiner?   | ospital:   |                                      | Oth  |                                      | eath (Check only                          | one)                     |  |   |
| of         | ding Physicien: The I<br>h.<br>After this certificate ha<br>funeral director, page   | lon; To          | 27. Manner of Death  1 Natural 5 Pending   | 1 Inpatient 2  28a. Date of Injury (Month, Day Year)   | 28b. Time of Injury                  | 28c. Injur   | 4 □ Nursing<br>y at<br>k?            | Home 5 Resi<br>28d. Describe              |                          | Other (Speci                                   | fy)   |
| Division   | To the Hospitel or Attending within 24 hours after death.  To the Funerel Director: After completely filled in by the fune   | Certification;   | 2 Accident investigation 3 Suicide 6 Could not be determined   | 28e. Place of Injury - At building, etc. (Spec   | home, farm, streetfy)                |  | Yes 2 □ No                           | 28f. Location (<br>City or To             | Street and<br>wn, State) | d Number or Rur<br>)                           | al Route Number,                              |
|            | Ne Hospi<br>24 hou<br>ie Funer<br>letely fill  | Medical          | 29a. Certifier (Check only one)  1 Certifying Phys 2 Medical Examin  | sician: To the best of my kener: On the basis of examinand manner stated.                      | nowledge, death<br>nation and/or inv | occurred at the tin<br>restigation, in my o                  | ne, date and pla<br>pinion, death oc | ce, and due to the<br>curred at the time, | cause(s)<br>date and     | and manner as a<br>place, and due t            | stated.<br>o the cause(s)                     |
| <b>)</b>   | To the To the comp   | Me               | 29b. Signature and title of certifier  | Houl N   | ·)                                   | 29c. Licens  |                                      |   | _                        | e signed (Month,                               |   |
|            | 10   |                  | 30. Name and address of person who co  | mpteted cause of death (It   | em 23a) (Type,                       | Print)   |                                      | zn Ne                                     | DEC                      | K NE   | 19711   |
|            | Sta<br>Registi   |                  | 31. Date filed (Month, Day, Year)  | 32. Registrar's Sig  | nature                               | well!  | 110                                  | /00                                       |                          | <i>U-</i>                                      | 1-011   |

Registrar

DEC 2 3 2005

Brother Paul Schuler

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend 1 tem 28b, per meo 8850 12-23-05 vt.

| C                              | 11   |                | America   | State of                                  | <b>p per</b><br>Marylan |                            |                                 |                     |                         | ind M                   | ental Hy                       | gien            | nn                      | 5                     | 4163                            | 27            |
|--------------------------------|--|----------------|---|---|-------------------------|----------------------------|---------------------------------|---------------------|-------------------------|-------------------------|--------------------------------|-----------------|-------------------------|-----------------------|---------------------------------|---------------|
|                                |  |                | 1 - Stete<br>Registrar  |   |                         | Ce                         | rtificate                       | of D                | eath                    |                         |                                | Reg. No         |                         |                       | 7100                            | - /           |
|                                | Physici  | an             | Decedent's Name (First, Middle, La.  T  | -   | 1111                    |                            |                                 |                     |                         |                         | 2. Date of De.<br>Month        | ath<br>Da       | у                       | Yeer                  | 3. Time of                      | Death         |
|                                | /Medic   | al             | 4a. Facility Name (If not institution, giv                                    | inda Ann                                  |                         |                            | 4b. City, To                    | wn orl              | ocation o               |                         | Decembe                        | -               |                         | 005<br>of Death       | 8:49P                           |               |
|                                | Examin   | er             | 1200 Blk Singerl  | 1000                                      | ~,                      |                            | Elkto                           |                     |                         | Douth                   |                                |                 | ecil                    | OI DOUL               |                                 |               |
|                                | Funeral  |                | 5. Social Security Number 6. S  | iex 7.                                    | Age (In yrs.            | last birthday)             | If Under 1 Y                    |                     | If Under 2              | 24 Hrs.                 | 8. Date of Bird<br>(Month, Da  | th              |                         | 9. Birth              | place (State or                 | r Foreign     |
| ш                              | Director   |                | 167-40-3065   | □M 2MTF                                   | 58                      | Yrs.                       | WOITERS                         | ays                 | Hours                   | WILL 1.                 | May 13                         | , 19            | 47                      |                       | nsylva                          | nia_          |
|                                | and w  |                | Usual Residence of Decedent  10a. State 10b. County                           |   | 10c. Cit                | y, Town or Lo              | ocation                         |                     |                         |                         |                                |                 | 10d. Inside City Limits |                       |                                 | y Limits      |
|                                | Maryl<br>-f ehc  | ţō             | Maryland Cecil  |   | E                       | 1kton                      |                                 |                     |                         |                         |                                |                 |                         |                       | 1 💢 Yes                         | 2 🗌 No        |
|                                | r 28a  | Director       | 10e. Street and Number  |   |                         |                            | 10f. Zip Co                     | ode                 |                         |                         |                                | 10g. Ci         | izen of V               | What Cou              | intry?                          |               |
|                                | 23a c  | ai             | 309 Elkton Boul   | .evard                                    |                         |                            | 219                             |                     |                         |                         |                                | _               | Inite                   | ed St                 | ates                            |               |
|                                | tema<br>serm   | Funeral        | 11. Marital Status  | 12. Was Decede<br>Armed Force             | es?                     | .S. 13.                    | Was Deceden<br>If Yes, specify  | t of Hist<br>Cuban, | panic Orig<br>, Mexican | gin? (Spe<br>, Puerto l | cify Yes or No<br>Rican, etc.) | -               |                         | e - Amer<br>ck, White | ican Indian,<br>, etc.          |               |
| 36                             | rs after   | by F           | 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced                        | 1 ☐ Yes 2<br>If Yes, Give<br>Year or Date |                         |                            | 1□Yes 2X                        | No                  | Specify:                |                         |                                |                 | Specify                 | Wh:                   | ite                             |               |
| 9                              | be filed within 72 hours after death with the Maryland nat Hygiene of other than "naturel", or itema 23a or 28s-f ehow event, I're Medical Exartical must be conflied at         | ted            | 15. Decedent's E  | ducation                                  |                         |                            | dent's Usual C                  |                     |                         | af un dei               |                                | 16b. K          | ind of Bu               | usiness/li            |                                 |               |
| 218                            | e.<br>en en  | Completed      | (Specify only highest gra<br>Elementary/Secondary (0-12)                      | College (1-4                              | or 5+)                  | life.                      | kind of work of<br>DO NOT use r | retired)            | ırıng mosi              | OF WORK!                | ig                             |                 |                         |                       |                                 |               |
| 21                             | ygien<br>ygien<br>her th   |                | 17. Catada Nasa (Cara Middle Land   | 3   |                         | Reg                        | <u>istere</u>                   |                     |                         | d- No                   | (First, Middle,                |                 |                         | h Ca                  | ire                             |               |
| and                            | ntal H<br>ed ot  | Be             | 17. Father's Name (First, Middle, Last,  John Isaac Hill                      |   |                         |                            |                                 |                     |                         |                         | . Seide                        |                 | Juman                   | 10)                   |                                 |               |
| Z                              | 2 should be filed within and Mental Hygiene. ie marked other than aumatic event, the Me  | ဥ              | 19a. Informant's Name/Relationship (  |   |                         | 19b. Maili                 | ng Address (S                   | Street an           |                         |                         | Route Number                   |                 | or Town,                | State, Zi             | p Code)                         |               |
| M                              | alth an 27 io  |                | James D. Hull/H   | lusband                                   |                         |                            |                                 |                     |                         |                         | E1kton                         |                 |                         |                       |                                 |               |
| ore,                           | ges 1 and 2 should<br>t of Health and Men<br>if Item 27 ie marke<br>or other traumatic   |                | 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐                       | Domaval from St                           |                         | amatani ara                | osition (Name<br>matory or othe | of<br>or place)     | )                       | Dece                    | mber                           | 20c. L          | ocation -               | City or T<br>nwa1     | own, State                      |               |
| Ë                              | Pag<br>ment<br>ant: if<br>ury o  |                | 4 Donation 5 Other (Special   |   | OC!                     | meterv                     | ard                             |                     |                         | 21,                     | 2005                           | Per             | nnsy                    | 1van                  | ia                              |               |
| Baltimore, Maryland 21215-0036 | permit. Pages 1 and 3<br>Depertment of Health<br>Important: If Item 27<br>eny injury or other tr.<br>once.   |                | 21. Signature of Funeral Service Licer  | 1500                                      | à.                      | Ĥ                          | Name and A                      | Address<br>Ome      | for                     | Fune                    | rals, F<br>eet, El             | .A.             | . M                     | 1                     | - 1 010                         | <b>101</b>    |
|                                |  |                | 23a. Part1. Enter the disease, or com   | plications that cau                       | used the deat           | h. Do not en               | ter the mode o                  | of dying,           | such as                 | STI:                    | r respiratory ai               | KTO             | n, M                    | aryı                  | Approximate                     | 9             |
|                                | Physician  |                | shock, or heart failure. List only<br>Immediate Cause (Final                  | one cause on eac                          | th line.                | 5.5.4                      | Cias                            |                     |                         |                         |                                |                 |                         |                       | Interval Betw<br>Onset and D    | reen<br>Jeath |
|                                | /Medical   |                | disease or condition<br>resulting in death)                                   | a. Due to (or                             | as a conseq             | uence of)                  | <u>u</u> (4-                    |                     |                         |                         |                                |                 |                         |                       |                                 |               |
|                                | Examiner   | Œ.             | Sequentially list conditions,   | b   |                         |                            |                                 |                     |                         |                         |                                |                 |                         |                       |                                 |               |
|                                | bd sit   | liner          | if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | Due to (or                                | ras a conseq            | uence of):                 |                                 |                     |                         |                         |                                |                 |                         |                       |                                 |               |
| •                              | cate be executed<br>physicien end<br>the burial-transit  | Examiner       | that initiated events<br>resulting in death) Last                             | c. Due to (or                             | as a conseq             | uence of):                 |                                 |                     |                         |                         |                                |                 |                         | -                     |                                 |               |
| 68760,                         | sicier<br>b buris  | dical E        |   | d   |                         |                            |                                 |                     |                         |                         |                                |                 |                         |                       |                                 |               |
| .89                            | tificati<br>g phy<br>as the  | ledic          |   |   | -                       |                            |                                 |                     |                         |                         |                                |                 |                         |                       |                                 |               |
| Box                            | death certificate be executed<br>e ettending physicien end<br>of for use as the burial-transit   | an/N           | IF FEMALE:<br>23b. Was decedent pregnant                                      | 23c. If yes, outco                        | me of pregna            |                            | DEctopic pregr                  | nancy               |                         |                         |                                |                 |                         | e of deliv            | •                               | ·             |
| -                              | the ett  | Physician/Me   | in the past 12 months?<br>1 □ Yes 2 □ No<br>9 ☑ Unknown                       |   | nt at time of d         |                            | Other (speci                    |                     |                         |                         |                                |                 | Moi                     | ntn                   | Day Y                           | 'ear          |
| P.0                            | The law requires that the de<br>sie hes been signed by the e<br>bage 2 should be detached (  |                | Part If. Other significant conditions   | contributing to dea                       | th but not res          | ulting in the u            | Inderiving caus                 | se aiven            | n in Part I.            |                         | 23e. Did to                    | obacco          | use conti               | ribute to             | the cause of de                 | eath?         |
| of Vital Records,              | uires the<br>signed<br>Id be del   | d by           |   |   |                         |                            |                                 |                     |                         |                         | 101                            | res 2           | No                      | 3 🔲 Pro               | bably 4 🗆 U                     | nknown        |
| S                              | w require<br>s been si<br>should t   | Completed      |   |   |                         |                            |                                 |                     |                         |                         | 24a. Was                       |                 |                         | Were aut              | opsy findings a ompletion of ca | ivailable     |
| Re                             | The law<br>te hes  | omp            |   |   |                         |                            |                                 |                     |                         |                         | autop<br>perfo                 | rmed?<br>2 ☐ No |                         | prior to co<br>death? | ompletion of ca<br>2□ No        | use of        |
| ital                           | ien:<br>ortifice<br>ctor, p  | Bec            | 25. Was case referred to medical examiner?                                    |   |                         |                            |                                 |                     | 26. Place               | of Death                | (Check only o                  |                 |                         | 7.00                  | 20110                           |               |
| ∑ <                            | Physicien:<br>this certific<br>ral director,   | 2              | 1 ☐ Yes 2 ☐ No  | Hospital: 1 🗆 Inp                         |                         |                            | nt 3 DOA                        | Other               | 4 🔲 NU                  | rsing Hor               | ne 5 Resid                     |                 | 22                      | er (Speci             | y) scen                         | ie            |
|                                | Jing F   | Certification: | 27. Manner of Death t Natural 5 Pending                                       | 1 6 7                                     | Injury<br>Day Year)     | <sup>286</sup> <b>20</b> ; | 40 28c.                         | Work?               | at<br>es 2.0⊠(t         | 10                      | 16 Ver c                       |                 | ry occurr               | ed vel                | ricle                           |               |
| Division                       | Attenderation of the   | fical          | 2 Accident investigatio 3 Suicide 6 Could not be determined                   | 28e. Place of                             | f Injury - At he        | ome, farm, st              | reet, factory, o                |                     | 03 2 /4                 | - 1                     | AVO VCe<br>28f. Location (S    | Street ar       | Collind Numb            | er or Rur             | al Route Numb                   | DB1, A        |
| Ö                              | alor/s after   | Serti          | 4 Homicide determined   | building                                  | g, etc. (Specif         | 3766                       | 4                               |                     |                         |                         | City or Tov                    | m State         | 25                      | Sins                  | erly f                          | Doel          |
|                                | To the Hospital or Attending Physicien: The I within 24 hours after death. To the Funerel Director: Atter this certificate he completely filled in by the funeral director, page |                |   |   |                         |                            |                                 |                     |                         | and due to the          | cause(s                        | ) and ma        | inner as s              | stated.               |                                 |               |
|                                | the H<br>hin 24<br>the F<br>nplete   | Medical        | one)  | and manne                                 |                         | ori aria/oriif             |                                 |                     |                         |                         |                                |                 |                         |                       |                                 |               |
|                                | To To Con  | -              | 29b. Signature and title of certifier   |   |                         |                            |                                 |                     |                         | Day, Year)              |                                |                 |                         |                       |                                 |               |
| 7                              |  |                | 30-Name and address of person who   | completed cause                           | of death (line          | n 23a) /Timo               |                                 | CME                 |                         |                         |                                | Dece            | embe:                   | r 16                  | , 2005                          |               |
|                                |  |                | TATO ICIA   | TON CA                                    | - RI                    | 1                          |                                 | n St                | reet                    | , Ba                    | ltimore                        | e, Ma           | ary1a                   | and 2                 | 21201                           |               |
|                                | Sta  | ate            | 31. Date filed (Month, Day, Year)   | 32. Beg                                   | gistrar's Signa         |                            | banks                           |                     |                         |                         |                                |                 |                         |                       |                                 |               |

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 0 0 5 For State Registrar Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Month Physician Skodec 5:18AM 5, December 2005 /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Hebrew Home Rockville Montgomery If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 12/31/1923 9. Birthplace (State or Foreign Country) Czechoslovakia 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** 1⊠M 2□ F 055-30-8999 81 Director Usual Residence of Decedent with the Maryland show 10b. County 10c. City, Town or Location 10d. Inside City Limits 27 is marked other than "naturel", or items 23s or 28e-1 show treumetic event, the Manical Experiment reust by rediffied at 1 ▼ Yes 2 No Director Maryland Montgomery Rockville 10e Street and Number 10f. Zin Code 10g. Citizen of What Country? 1700 Lorraine Drive 20852 USA deeth Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Importent: If liem 27 is marked other than "naturel", or ites any injury or <u>other</u> treumetic event. The Market of the state Black, White, etc. ☐ Yes 2 No f Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married Baitimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 5+ Nuclear Engineer Federal Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Frantisek Skopec Antonia Zlamal 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ana Skopec / Spouse 1700 Lorraine Drive; Rockville, MD 20852 injury or other t 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State \* 4 ☐ Donation 5 ☐ Other (Specify) Gate of Heaven Cemet, 12/9/2005 Silver Spring, MD 22. Name and Address of Facility
Simple Tribute Funeral and Cremation Center
1040 Rockville Pike; Rockville, MD 20852 21. Signature of Fun rell Service Livensee, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ongestive **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to or as a consequence of): Examine The law requires that the death certificate be executed ng physician and as the burial-transit Coronan that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: use 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy õ in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the a ☐ Yes 210 16 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 99 1 Yes 2 No 3 Probably 4 Unknown page 2 should Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed 2 40 1 Yes 2 No To the Hospitel or Attending Physician: funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Drursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner eath 28b. Time of 28d. Describe how injury occurred After 1 Litatural 5 Pendina after death.

Director: Af
d in by the fu 1 ☐ Yes 2 ☐ No 2 Accident investigation 3 🗀 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funerel [ filled Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) Signature and title of certifier O 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MPH 6121 Montrose Rd., Rockville, MD Sayed MD. Joce lun 31. Date filed (Month, Day, Year) 32 Registrar's Signature State 09 2005 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygieflen Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 6, 2005 Month December 11:35A M Stansill Betty Louise 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Montgomery Rockville Shady Grove Hospital 9. Birthplace (State or Foreign Country) Virginia If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number Min Months Days Hours 1 M 2 F 78 Yrs 231-24-4519 Usual Residence of Decedent 10d. Inside City Limits 10a State 10b. County 10c. City, Town or Location 1 ☑ Yes 2 ☐ No Maryland Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 20850 630 Blandford Street 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 No Specify: 3X Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Medical Switchboard Operator 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Nelly McCoy James Forrest 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 630 Blandford St.; Rockville, MD 20850 Robert Stansill / Son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Ft. Lincoln Crematory 12/10/2005 Brentwood, Maryland \$ □ Other (Specify) 4 Donation eral Service Licen 21. Sign your of Fur Simple Tribute Funeral & Cremation Center 1040 Rockville Pike; Rockville, MD 20852 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or expiratory afrest, shock, or heart failure. List only one cause or each line. Approximate Interval Between Onset and Death Immediate Cause (Final 0 disease or condition resulting in death) ue to (or as a consequence) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes No
9 Unknown Month Day Year 4☐ Pregnant at time of death 5 Other (specify) 9□ Unknown 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably

Physician /Medical Examiner

Department of H
Importent: If Ite
any injury or oth

**Physician** 

/Medical

Examiner

**Funeral** 

Director

28a-f show

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or iteme

Pages 1 and 2 should be filed within 72 hours after inent of Health and Mental Hygiene. ent: If Item 27 is marked other than "natural", or Ite

Baltimore, Maryland 21215-0036

Director

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Completed

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other treumatic svent, the Medical Exeminar must be notified at

Examiner ettending physicien and for use es the burial-transit been signed by the should be detached certificate has b this

The law requires that the death certificate be executed

To the Hospitel or Attending Physician:

death.

within 24 hours a

Medical

After thi

Director: /

Division of Vital Records, P.O. Box 68760,

Physician/Medical þ Completed Be 25. Was case referred to medical 2 Certification:

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. Was an autopsy performe 1 Yes 2[

28d. Describe how injury occurred

24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No

26. Place of Death Check only Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

1 Inpatient 27. Manner of eath 28a. Date of Injury (Month, Day Year) 28b. Time of 5 Pending Natural investigation 2 Accident 6 Could not be determined 3 Suicide

1 Yes 2 No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

3□ DOA

28c. Injury at Work?

2 ER/Outpatient

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one 29b. Signature and title of certifier

examiner?

1 🗌 Yes

4 Homicide

25

and manner stated. 29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

9900 Medical Center Drive; Rockville, MD 20850 William Dooley, M.D.

State Registrar 31. Date filed (Month, Day, Year) 0 9 2005

|  |  | -                       | For<br>State<br>RegistraMEND#5perFH1.   | State of Maryland  |                            |                                |  |                               | giene 0          | 15                   | 41630  |
|--|--|-------------------------|---|--|----------------------------|--------------------------------|--|-------------------------------|------------------|----------------------|--|
| 74   | 5  | _                       | Decedent's Name (First, Middle, Last)   | ,,,,,,,,,, -   |                            |                                |  | 2. Date of Dea                | ath              |                      | 3. Time of Death                               |
| -  | Physicia   | _                       | ETON ANTHO  | NY TH  | OMAS                       |                                |  | Month<br>Dec. 5               | Day 200!         | Year<br>5            | 9:55P M  |
|  | /Medic<br>Examin   |                         | 4a. Facility Name (If not institution, give st  |  |                            | lb. City, Town,                | or Location of Death                         |                               | 4c. County       |                      |  |
|  |  |                         | Holy Cross Hosp   | ital   |                            | Silv                           | er Sprin                                     | ıg                            | Moi              | ntgo                 | mery   |
|  | Funeral  |                         | 5 Social Security Number 6. Sex   | 7. Age (In yrs. la   | A                          | If Under 1 Year<br>Months Days |  | 8. Date of Birt<br>(Month, Da | y, Yea <i>r)</i> | 9. Birth             | place (State or Foreign intry)                 |
| ×  | Director   | j:                      | <del>216-13-7917</del>  | 37   | Yrs.                       |                                |  | Aug.3                         | 1968             |                      | h, DC  |
|  | and and  | }                       | Usual Residence of Decedent  10a. State 10b. County   | 10c. City  | , Town or Local            | tion                           |  |                               |                  |                      | 10d. Inside City Limits                        |
|  | Many!  | 0                       | MD Montgom  | erv  | Silve                      | r Spri                         | ng   |                               |                  |                      | Yes 2□No                                       |
|  | 288-   | Director                | 10e. Street and Number  |  |                            | 10f. Zip Code                  |  |                               | 10g. Citizen of  | What Cou             | intrv?   |
|  | With<br>Ba or  |                         |   | on.  |                            |                                | 901  |                               | U.S.A            |                      | ,  |
|  | Jeath<br>The 2:  | Funeral                 | 1301 Forest G1  | 2. Was Decedent Ever in U.S                                  | 6. 13. Wa                  |                                | Hispanic Origin? (Sp<br>ban, Mexican, Puerto | ecrfy Yes or No               |                  | ce - Amer            | ican Indian,                                   |
| (0   | r Ita  | F                       | 1 Never Married 2 Marned  | Armed Forces?<br>1 ☐ Yes X2 ☐ No                             |                            | es, specify Cu<br>⊇Yes 2□ No   |  | Rican, etc.)                  |                  | ick, White           | •  |
| 03   | hours after death with the Maryland<br>turet; or Itams 23a or 28a-f show<br>at Examir at must be notified at   | þ                       | 3 Widowed 4 Divorced  | If Yes, Give<br>Year or Dates:                               | 1 L                        | JYes 2∐No                      | o Specify:                                   |                               | Specif           | bla                  | .ck  |
| 21215-0036   | 72 hc  | Completed               | 15. Decedent's Education (Specify only highest grade  | ation<br>completed)  | 16a. Deceder<br>(Give kir. | nt's Usual Occi                | upation<br>e during most of work             | ing                           | 16b. Kind of B   | Business/I           | ndustry  |
| 21   | ithin  | du                      | Elementary/Secondary (0-12)   | College (1-4or 5+)   | life. DO                   | NOT use retir                  | e during most of work<br>red)                |                               | Coac             |                      |  |
| 2  | led w<br>lygier<br>her ti  |                         | 12th  |  | Cour.                      | ier                            | 40 Markada Nasa                              | - /Ci A4:33:                  | Carr             |                      | Co   |
| n o  | be fill  | Be                      | 17. Father's Name (First, Middle, Last)   |  |                            |                                | 18. Mother's Nam                             |                               |                  | me)                  |  |
| <u> </u>   | 1 Mer<br>nark  | ို                      | Percy E. Thom 19a. Informant's Name/Relationship (Typ   |  | 10h Mailine                | Addense /Com                   | et and Number or Rur                         | ona V.                        |                  | Cto to 7             | in Code l                                      |
| Mai  | d2st<br>than<br>7 Isr  |                         | Victoria Thomas   |  |                            |                                |  |                               |                  |                      | MD20901  |
| Baltimore, Maryland                                  | parmit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hydiene.  Department if them 27 is marked other than "natural; or itams 23a or 28a-1 show any injury or other traumatic event, the Medical Examinar must be notified at once. |                         | 20a. Method of Disposition  |  | aca of Dispositi           |                                |  | Date                          | 20c. Location    |                      |  |
| ē  | Op H of  | 9                       | ¥ Burial 2 ☐ Cremation 3 ☐ Re   | moval from grane   | 4.1                        |                                |  | 13/05                         | Adelp            |                      |  |
| 턡  | ntan<br>Injury   |                         | 4 ☐ Donation 5 ☐ Other (Specify)  21. Sign use of Funeral Service Licenses                                  | -  | Singe W                    |                                | ress of Facility Sno                         |                               |                  | •                    |  |
| Ва   | permii<br>Depar<br>Impor<br>any In   | 9 1                     | Mosion  | Lunush   |                            |                                | Washingto                                    |                               |                  |                      |  |
| 12. II   | *  |                         | 23a. Part1. Enter the disease, or complic shock, or heart failure. List only one                            | ations that caused the death                                 |                            |                                |  |                               |                  | i                    | Approximate                                    |
| A Partie   | Obvoicion  |                         | Immediate Cause (Final  | NON HOI  |                            |                                |  |                               |                  |                      | Interval Between<br>Onset and Death            |
|  | Physician<br>/Medical  |                         | disease or condition resulting in death)  | Due to (or as a consequ                                      |                            | D HIII                         | 1101111                                      |                               |                  |                      | 18Months                                       |
| and the second                                       | Examiner   |                         | 4   | 200 10 (0. 00 0 000040                                       |                            |                                |  |                               |                  |                      |  |
|  |  | Jer                     | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | Due to (or as a consequ                                      | ience of):                 |                                |  |                               |                  |                      |  |
| 2  | cuted<br>nd<br>ransit  | Examiner                | that initiated events C.  |  |                            |                                |  |                               |                  |                      |  |
| 00   | e exe<br>ian ar<br>ırial-t   | Ë                       | resulting in death) Last  | Due to (or as a consequ                                      | ience of):                 |                                |  |                               |                  |                      |  |
| 70.00  | cate be executed<br>physician and<br>s the burial-transit  | dlcal                   | d.  |  |                            |                                |  |                               |                  | -                    |  |
| ဍဖ   | certifica<br>nding plans as t  | 0                       | IF FEMALE:  |  |                            |                                |  |                               |                  | -                    |  |
| did Box  | death ce<br>e attend<br>ed for usi   | lan/                    | 23b. Was decedent pregnant in the past 12 months?   | ic. If yes, outcome of pregnar<br>1 ☐ Live birth 2 ☐ Fetat   | death 3□E                  | ctopic pregnar                 |  |                               |                  | ate of deli-         | very<br>Day Year                               |
| 40.  | the a  | Physician/M             | 1 ☐ Yes 2 ☐ No<br>9 ☐ Unknown   | 4☐Pregnant at time of de<br>9☐Unknown                        | eath 5□C                   | Other (specify)                |  |                               |                  |                      | ,  |
| ga.  | w requires that the death certific<br>been signed by the attending p<br>should be detached for use as  |                         | Part II. Other significant conditions cont  | ributing to death but not resu                               | ilting in the und          | erlying cause of               | given in Part I                              | 23e. Did t                    | obacco use con   | ntribute to          | the cause of death?                            |
| ds, k  | signe<br>d be  | Completed by            | Acquire Immune  |  |                            | , ,                            | <b>.</b>                                     |                               | Yes 2⊠No         |                      | bably 4 Unknown                                |
| Sord   | requ<br>been<br>shoul  | ete                     | 710044220 211111411   | 3  |                            |                                |  | 24a. Was                      | 24h              | Moro au              | tangu findinga ayaylahla                       |
| Se -   | e las  | m<br>du                 |   |  |                            |                                |  | autor                         |                  | prior to c<br>death? | topsy findings available ompletion of cause of |
| \$ <del>=</del>                                      | ician: Th<br>certificate<br>rector, pag  |                         | 25. Was case referred to medical  |  |                            |                                |  | 1 ☐ Yes                       | 2 🖾 No           | 1 🗆 Yes              | 2[ <b>X</b> No                                 |
| > = = = = = = = = = = = = = = = = = = =              | sicia<br>certi   | o Be                    | examiner?   | ospital:   | ER/Outpatient              | 3□ DOA                         | 26. Place of Deal<br>Other: 4 Nursing Ho     |                               |                  | hor (Case            |  |
| 2.0  | Attending Physici<br>r death.<br>sctor: Atter this ce<br>by the funeral direc  | 7: To                   | 27. Manner of Death   | 28a. Date of Injury<br>(Month, Day Year)                     | 28b. Time of               | 28c. In                        | 4 C 1 1 4 1 5 1 1 9 1 1                      |                               | how injury occu  |                      | ny)  |
| o uo   | ath.: Afte   | tloi                    | 1 XNatural 5 ☐ Pending 2 ☐ Accident investigation   | (Month, Day Year)  | Injury                     |                                | /ork?<br>☐ Yes 2 ☐ No                        |                               |                  |                      |  |
| -Ok per V Tevry bee. S<br>Division of Vital Records, | Atte   | 1                       | 3 ☐ Suicide 6 ☐ Could not be determined   | 28e. Place of Injury - At ho<br>building, etc. (Specify      | me, farm, stree            | et, factory, offic             | :0   | 28f. Location (<br>City or To |                  | ber or Ru            | ral Route Number,                              |
|  | To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,  | Certification:          |   | Dunding, etc. (Specify                                       |                            |                                |  | 5.1, OI 10                    | , o.a.o/         |                      |  |
| 4  | ospital<br>hours<br>uneral<br>ily filled   |                         |   | ician: To the best of my known: or: On the basis of examinat |                            |                                |  |                               |                  |                      |  |
| - American   | the H<br>nin 24<br>the Fi  | Medical                 | one)  | and manner stated.   | Serial Control             |                                |  | at the time,                  |                  |                      |  |
|  | To t<br>To t   | 2                       | 29b. Signature and title of certifier   | a lacen  | )                          |                                | nse number                                   |                               | 29d. Date sign   |                      | ,  |
|  | 10   |                         | , 000   |  |                            | D33                            | 3224   |                               | Dec.             | 6,                   | 2005   |
| R  | ( -  |                         | 30. Name and address of person who con  |  |                            |                                | D4#42E C                                     | 1 1 1 7 7 7 7                 | Carina           | ~ N/I                | חופחב ת  |
| (5)  |  |                         | Mr. Ram Trehan 31. Date filed (Month, Day, Year)  | MD 1900 F  | orest                      | Gren                           | KU#433 S                                     | river                         | Phrtud           | <b>ع</b> , ™         | D 20310  |
|  | Sta<br>Regist  | ate <sup>©</sup><br>rar | DEC 0 9 200   | 15 Brace D   | ture                       |                                |  |                               |                  |                      |  |

Baltimore, Maryland 21215-0036

**Physician** /Medical Examiner

burial-transit

use as the

jo

s been signed by the should be detached

page 2 this certificate has

filled in by the funeral s after death.

within 24 hours a To the Funerel L

mp

the attending physician and

The law requires that the death certificate be executed

or Attending Physician:

Division of Vital Records, P.O. Box 68760,

Examiner

Physician/Medical

Completed by

Be

Certification: To

Medical

Reg. No.

PRINCE GEORGE'S

**Physician** /Medical

WILLIAM CLINTON TRAVIS

DECEMBER 6, 2005

2. Date of Death

3. Time of Death 9:45 AM

4a. Facility Name (If not institution, give street and number) SOUTHERN MARYLAND HOSPITAL 4b. City, Town, or Location of Death CLINTON

4c. County of Death

216-22-2741

7. Age (In yrs. last birthday) 78

If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Months

8. Date of Birth DECEMBER 6, 1927 WASHINGTON, DC

9. Birthplace (State or Foreign

Usual Residence of Decedent

10a. State 10b. County 10c. City. Town or Location

10d. Inside City Limits

1 ☐ Yes 2**X**☐ No

CHARLES

LAPLATA

10f. Zip Code 20646

10g. Citizen of What Country? UNITED STATES

10e. Street and Number 6100 BIVINS PLACE

11. Marital Status

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give

 Was Decedent of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 🛣 No Specify:

14. Race - American Indian, Black, White, etc.

3 ☐ Widowed 4 ☐ Divorced

15. Decedent's Education (Specify only highest grade completed)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

BLACK 16b. Kind of Business/Industry

Specify:

Elementary/Secondary (0-12)

Cotlege (1-4or 5+)

CONSTRUCTION WORKER

17. Father's Name (First, Middle, Last)

18. Mother's Name (First, Middle, Maiden Sumame)

CONSTRUCTION

WILLIAM COURTNEY TRAVERS

DOROTHY HENRIETTA BROWN TRAVERS 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

19a. Informant's Name/Relationship (Type, Print) CHERYL TRAVIS/DAUGHTER

20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition

5604 WINDSOR COURT, SUITLAND, MARYLAND 20746 Date 20c. Location - City or Town, State

1 \$\infty\$ Buriat 2 □ Cremation 3 □ Removat from State
'4 □ Donation 5 □ Other (Specify)

SACRED HEART CHURCH CEM

DEC 12, 2005 LAPLATA, MARYLAND

21. Signature of Funeral Services Censes LYDIA C. THORNTON JOHNSON

22. Name and Address of Facility
THORNTON FUNERAL HOME, P. A 3439 LIVINGSTON ROAD, INDIAN HEAD, MD 20640 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

tmmediate Cause (Final disease or condition resulting in death)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

| UNCONTROLLED H              | <b>IYPERTENSION</b> |
|-----------------------------|---------------------|
| Due to (or as a consequence | e of):              |
|                             |                     |

Due to (or as a consequence of)

Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 9 🗆 Unknown

23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death

9 Unknown

3 Ectopic pregnancy 5 Other (specify)

23d. Date of delivery Month Day

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown

Year

Hospital:

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. Was an autopsy performe

24b. Were autopsy findings available prior to completion of cause of death?

1 🗌 Yes 2 X No 26. Place of Death (Check only one)

2 \( \text{No} \)

25. Was case referred to medical examiner? 1 ☐ Yes 2 X No 27 Manner of Death

**X**Natural

2 Accident

3 Suicide

4 Homicide

5 Pending investigation 6 ☐ Could not be

determined

1 X Inpatient 28a. Date of Injury (Month, Day Year)

Other: 4 Nursing Home 2 ER/Outpatient 3 DOA 28b. Time of Injury

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

5 ☐ Residence 6 ☐ Other (Specify)

12-07-05

29a. Certifier

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicat Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature and title of Cartifier

29c. License number D46478

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

7501

SURRATTS ROAD, CLINTON, MD 20735

SURESH A PATEL MD State Registrar

DEC 0 0 9 32. Registrar's Signature

28e. Ptace of Injury - At home, farm, street, factory, office building, etc. (Specify)

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Dav Yeer **Physician** KOPN 24DYS ANCE December Z ZOCA /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Pohl 5 -RUNDEL UNRISEOF If Under 1 Year 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Funeral Months 1 M 2 F Director 223-14-9135 84 FEB. 24, VIRGINIA 1921 Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits the Medical Exerciser count be notified at 1 ¥Yes 2 □ No Director ANNE ARUNDEL ANNAPOLIS 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? ŏ 23a SUNRISE OF ANNAPOLIS, 800 BESTGATE RD. 21401 U.S.A. Funeral Race - American Indian, Black, White, etc. or itsms 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Yes 2 MNo If Yes, Give Year or Dates: filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: b Specify: 3 XWidowed 4 □ Divorced WHITE "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) permit. Peges 1 end 2 should be filed with Deportment of Health and Mental Hygiene Important: If itsm 27 is marked other that say linjury or other traumatic event, that once SECRETARY UNIVERSITY OF MARYLAND 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဂ္ LAWRENCE TALIAFERRO BERTIE BLANCHE MADISON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JOHN W. TALIAFERRO/NEPHEW 404 HAMPSHIRE CT., RIVA, MD. 21140 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) CHAMBERS CREMATORY DEC. 9, 2005 RIVERDALE, MD. 21. Signature of Funeral Service Lightsee CHAMBERS FUNERAL HOME & CREMATORIUM, P.A. M00091 5801 CLEVELAND AVE., RIVERDALE, MD. 20737 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** DOMENTIA /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Physician: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Box 68760. by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) 4 Pregnant at time of death ed by the a Division of Vital Records, P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? HYPERTENSION 2 No 3 ☐ Probably 4 ☐ Unknown 1 Yes Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2□ No 24a. Was an autopsy 2 No 1 ☐ Yes ours after death.

seei Director: After this certific filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death Check only one Hospital: 1 Inpatient Other: 4 Nursing Home 5 esidence 6 Other (Specify) 1 Yes/ 2 No Certification: To 2 ER/Outpatient 3 DOA 28c. Injury at Work? 27. Many of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a To the Funerel C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and maintoin as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number ddress of person who completed cause of death (Item 23a) (Type, Print) 860 31. Day filed (Month, Day, Year) 32 Registrar's Signature State 2005 Registrar DEC 0 9

| Daillinore, Maryland 21213-                | permit. Pages 1 and 2 should be filed within 72 h   |   |  |
|--|---|---|--|
|  | /N<br>Exa   | sicia<br>ledica<br>amine  |  |
| DIVISION OF VITAL RECORDS, P.O. DOX 56/60, | o the Hospital or Attanding Physician: The law requires that the death certificate be executed inthis 24 hours after death. | infinity at mounts show countries to settificate has been signed by the attending physicien and or this truncal Director. After this certificate to the funeral Director, page 2 should be detached for use as the buriel-transft ompletely filled in by the funeral director, page 2 should be detached for use as the buriel-transft. |  |

|  | 1                | For<br>State<br>Registrar  | Stat                                       |                                    | yland / D               |   | t of H             | ealth a     | and M          | lental Hyg                                  | •            | 05                     | 416   | 33             |
|--|------------------|--|--|------------------------------------|-------------------------|---|--------------------|-------------|----------------|---|--------------|------------------------|---|----------------|
| Physicia   | an               | Decedent's Name (First, M  |  | 2 12                               |                         |   |                    |             |                | 2. Date of Deat<br>Month                    | Day          | Year                   | 3. Time of                                  |                |
| /Medic   | al               | 4a. Fecility Name (If not institu  | ilip                                       | Antho                              | ony                     | Wet   |                    | 1 10        |                | Decembe                                     |              | 2005                   | 1:10  | A <sup>M</sup> |
| Examin   | er               | Frederick Me   |  | ,                                  | ı                       |   | eder               | Location    | or Death       |   |              | nty of Death           |   |                |
| Funoral  |                  | 5. Social Security Number  | 6. Sex                                     |                                    | n yrs. last birth       |   |                    | If Under    | 24 Hrs.        | 8. Date of Birth                            |              | deric                  |   | r Foreign      |
| Funeral<br>Director  |                  | 213-40-1559  | 1 Å M 2 €                                  |                                    | _                       | Months  | Days               | Hours       | Min.           | 8. Date of Birth<br>(Month, Day,<br>JULY 20 | , 1941       | THUR                   | lace (State or<br>htry)<br>MONT,            | MD.            |
|  |                  | Usual Residence of Deceden   |  |                                    | 0. 0. 7                 |   |                    |             |                |   |              |                        |   |                |
| o H  | 5                | 10a. State 10b. Cou  | •  | 1                                  | 0c. City, Town          |   |                    |             |                |   |              | 1                      | 0d. Inside Cit<br>1 ☐ Yes                   |                |
| 28a-1  | Director         | MD FRE   | DERICK                                     |                                    | THURMO                  | JN'1'<br>10f. Zip                                   | Code               |             |                | 11  | O Citizon o  | of What Cour           |   |                |
| Sa or  | ᅙ                | 16010 ST. A  | Р • УИОНТИ                                 | ROAD                               |                         | 101. 21   | 217                | 188         |                | ,   |              | S.A.                   | iti y :                                     |                |
| ms 2   | Funeral          | 11. Marital Status   | 12, Was                                    | Decedent Eve                       | er in U.S.              | 13. Was Dece  |                    |             | igin? (Sp      | ecify Yes or No-<br>Rican, etc.)            | 14. R        | ace - Americ           |   |                |
| or its   | F                | 1 Never Married 2 1  | Married 1 🔲                                | ed Forces?<br>Yes 2 No<br>es, Give |                         |   |                    |             |                | Rican, etc.)                                |              | lack, White,           |   |                |
| E  | d by             | 3 Widowed 4 Divor  |  | r or Dates:                        |                         | 1 🗆 Yes   | Z LAI INO          | Specify:    |                |   | Spec         | eny: WE                | IITE  |                |
| nation   | Completed        |  | dent's Education<br>ghest grade compl      | eted)                              | (                       | Decedent's Usu<br>Give kind of wo<br>life. DO NOT u | rk done o          | luring mos  | st of work     | ing   | 6b. Kind of  | Business/Ind           | dustry                                      |                |
| than   | фщo              | Elementary/Secondary (0-1  | 2) Coll                                    | ege (1-4or 5+)                     |                         | MECH  |                    | ,           |                |   |              | AUTO                   |   |                |
| Hyg<br>other   | BeC              | 17. Father's Name (First, Mid  | dle, Last)                                 |                                    |                         |   |                    | 18. Moth    | er's Nam       | e (First, Middle, N                         | aiden Sum    | ame)                   |   |                |
| Aenta<br>Aenta<br>rked<br>tic av   | To B             | HENRY RUSSE  | LL WETZ                                    | EL                                 |                         |   |                    | 1           | MARI           | ANA K.                                      | RODDY        | Z                      |   |                |
| and t  |                  | 19a. Informant's Name/Relat  | onship (Type, Prin                         | t)                                 | 19b. I                  | Mailing Address                                     | (Street a          | nd Numb     | er or Run      | al Route Number,                            | City or Tow  | m, State, Zip          | Code)                                       |                |
| fealth<br>m 27<br>har tr   |                  | MARIANA K. M   | YERS/SIS                                   |                                    |                         |   |                    | CHOO        |                | ., LITTL                                    |              |                        |   |                |
| or ot  |                  | 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremati  |  | 1                                  |                         | crematory or o                                      | ther place         |             |                |   |              | n - City or To         |   |                |
| perium regas i entre should be figure. Department of Health and Mental Highere. Department of Health and Mental Highere. Department of Health and Mental Highere. Insportant: if itam 27 is marked other than "natural", or itams 23a or 28a-f ahow any injury or other traumatic avant, the Medical Examinar must be notified at once.  |                  | 4 Donation 5 Other 21. Signature of Furgeral Sen   |  | 2 0                                | SMITHS                  | BURG CF   |                    |             |                |   |              |                        | MD. 2                                       | 1783           |
| Depa<br>Impo   |                  | La han   | m. Sk                                      | iles                               |                         |   |                    |             | 1              | SKILES I                                    |              |                        |   |                |
| histan   |                  | 23a. Part). Enter the disease<br>shock, or heart failure.<br>Impediate Cause (Final  | o, or complications<br>List only one cause | e on each line.                    |                         | t enter the mod                                     | e of dying         | g, such as  |                |   |              |                        | Approximate<br>Interval Betw<br>Onset and D | veen<br>Death  |
| hysician<br>/Medical   |                  | disease or condition<br>resulting in death)  | a  | ue to (or as a c                   | Static<br>onsequence of |   | rnc                | er          |                |   |              |                        | 2 100                                       | eks            |
| xaminer  |                  | Sequentially list conditions.  # applied of the interesting of the int |  |                                    |                         |   |                    |             |                |   |              |                        | 2 we  | eks            |
| B #5   | Examiner         | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury  |  |                                    |                         |   |                    |             |                |   |              |                        |   |                |
| requires inetitie destit betainds be executed been signed by the attending physicien and should be detached for use as the buriel-transit  | xan              | Cause (Disease or injury that initiated events c   |  |                                    |                         |   |                    |             |                |   |              |                        |   |                |
| ysicien and<br>buriel-transit  | calE             |  | <b>L</b> d                                 |                                    |                         |   |                    |             |                |   |              |                        |   |                |
| as th  |                  |  |  |                                    |                         |   |                    |             |                |   |              |                        |   |                |
| tendir<br>tendir   | an/h             | IF FEMALE:<br>23b. Was decedent pregnant   |  | s, outcome of p                    |                         | 3 Ectopic p   | egnancy            |             |                |   |              | Date of delive         |   |                |
| the at   | by Physician/Med | in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown  | 4 🗆  | Pregnant at tim<br>Unknown         |                         | 5 Other (sp   |                    |             |                |   | ,            | <b>Jonth</b>           | Day Y                                       | 'ear           |
| ad by<br>detacl  | Phy              | Part II. Other significant con   | ditions contribution                       | g to death but r                   | not resulting in t      | he underlying o                                     | ause aive          | n in Part I |                | 23e Did toh                                 | acco use co  | ontobute to th         | ne cause of de                              | nath?          |
| sign<br>d be   | d b              | Chronic  | <u> </u>                                   | and the second                     | ure                     | Hyi   | -                  |             |                |   | s 2 No       |                        | ably 4 April                                |                |
| been si  | lete             | Diabetes   |  |                                    | .,,,,                   | 1 71  |                    | 1 ~ 1       | <u>s ( 0 r</u> | 24a. Was ar                                 | 241          | Ware auto              | psy findings a                              | wadabla        |
| e has  | Completed        | oidisches  |  |                                    |                         |   |                    |             |                | autopsy                                     | ed?          | prior to cor<br>death? | npletion of ca                              | iuse of        |
| rtifical<br>tor, p   | a                | 25. Was case referred to me  | dical                                      |                                    |                         |   |                    | 26 Place    | e of Deat      | 1 ☐ Yes 2                                   | IPNo         | 1 🗆 Yes                | 2 No  |                |
| nja ce<br>I direc  | To B             | examiner?<br>1 Tes 2 No  | Hospital:                                  | 1 Inpatient                        | 2 ER/Outp               | atient 3 DC   | A Othe             | Ar-         |                | me 5 Reside                                 | -            | ther (Specify          | ()  |                |
| Miler ti   |                  | 27. Manner of Death 1 Natural 5 ☐ Pe   |  | Date of Injury<br>(Month, Day Y    | (ear) 28b. Tir          | ne of 2   | 8c. Injury<br>Work | at<br>?     |                | 28d. Describe ho                            | w injury occ | urred                  |   |                |
| tor; /   | cat              |  | estigation<br>uld not be                   | Di(1-i                             | 411                     | М   |                    | res 2 🗌     | No             |   |              |                        |   |                |
| This propriet of Attending Frightness. The tark requires the tipe death centure to the tipe of tipe of the tipe of tip | Certification:   | 4 ☐ Homicide de  | termined 286.                              | Place of Injury building, etc. (   | Specify)                | n, street, factor                                   | , office           |             |                | 28f. Location (Str<br>City or Town          |              | mber or Hura           | i Houte Numb                                | ) <i>61</i> ,  |
| nours<br>noral   |                  | 29a. Certifier 1 Cert  | itying Physician:                          | To the best of n                   | ny knowledge,           | death occurred                                      | at the tim         | e, date ar  | nd place,      | and due to the ca                           | use(s) and r | manner as st           | ated.                                       |                |
| n 24 h   | Medical          | (Check only 2 Medi   | car examiner: On                           | the basis of ex<br>manner stated   | tamination and          | or investigation                                    | , in my op         | oinion, dea | th occur       | ed at the time, da                          | te and place | e, and due to          | the cause(s)                                | )              |
| To t   | Σ                | 29b. Signature and title of cer  | tifier                                     |                                    |                         | 290   | . License          |             | - 1            | 28  | d. Date sign | ned (Month,            | Day, Year)                                  |                |
|  |                  | ) /m   |  |                                    |                         |   | De                 | 21          | 8 Ø            |   | 12-          | 20 -                   | 05  |                |
| 8  |                  | 30. Name and address of per  | /  |                                    |                         | ype, Print)   |                    |             |                | ederich                                     |              |                        |   |                |
| Sta  | te.              | Tauzi Ki   | ZVI, MT                                    | 32 Registrar's                     |                         | 1 171   | 211                | स्ला        | 1-4            | esurio                                      |              |                        |   |                |
| Registr  |                  |  | 3 2005                                     | 32 Registrar's                     | 15                      | gover   |                    |             |                |   |              |                        |   |                |

#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Deeth 1. Decedent's Name (First, Middle, Last) Dev Month 2005 8:50am Dec. Ervin White 4b. City, Town, or Location of Deeth 4c. County of Death 4e Fecility Neme (If not institution, give street end number) Prince Georges Pineview Nursing Home C1 inton If Under 1 Year If Under 24 Hrs. Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthdey) 8. Date of Birth (Month, Day, Year) Days Months 1 XM 2□ F Yrs. 82 255-20-0091 Oct.11,1923 GA Usuel Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 1 TyYes 2 □ No DC Washington 10g. Citizen of What Country? 10e. Street end Number 10f. Zip Code 2930 Knox Place, SE 20020 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Was Decedent Ever in U,S. Armed Forces? 1 ⊠ Yes 2 □ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Specify: Black 1943-1 ☐ Yes 2 ☑ No Specify: 3 ☐ Widowed 4 ☐ Divorced 944 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Unknown Private Contractor 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Neme (First, Middle, Last) Romie White Rosie L. Wilkins 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3400 Pearl Drive #2020746 20b. Place of Disposition (Name of cemetery, crematory or other place) Date Date Boisy White/nephew 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 12/9/05 Quantico Nat. Cem. Trian le, VA 22. Name and Address of Facility Hodges and Edwards 21. Signature of Funeral Service Licenses 3910 Silver Hill Rd.Suitland, Md. 20746 23a, Parl . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, splock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death CARDIOURCULAR DUGASE Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) Due to (or as a consequence of): Due to (or as e consequence of) 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was en autopsy performed?

Physician Weolcal Examiner

ed by the attending physician end datached for use es the burial-trensit

or Attanding Physician: The law raquiras that the daath certificate be executed

after death.

Director: After this certificata has been signe d in by the funeral diractor, paga 2 should be o

filled in by

within 24 hours a

To the Funeral I

completely filled

Division of Vital Records, P.O. Box 68760,

Physician/Medical Examiner

Completed by

Be

Medical Certification: To

Department of Health e Important: if Itam 27 ia any injury or other trat pice.

**Physician** 

/Medical

Examiner

10a, State

Funeral Director

Completed by

**Funeral** 

Director

f Health end Mental Hygiene. tam 27 is marked other than "natural", or items 23s or 28s-f show other traumatic event, the Medical Examinar must be notified at

Peges 1 and 2 should be filed within 72 hours after onent of Health end Mental Hygiene. Int: If Item 27 is merked other than "natural", or fre

Baltimore, Maryland 21215-0020

the Marylend

Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last

25. Was case referred to medical

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.

1 ☐ Yes 2 No 26. Place of Death (Check only one)

1 ☐ Yes 2 🛣 No

| examiner?<br>1 ☐ Yes 2 1 No               | Hospital: 1 ☐ Inpatient 2                | ☐ ER/Outpatient        | 3□ DOA | Other: 4 Nursing H | lome 5 🗆 Residence   | 6 □Other (Specify |
|---|--|------------------------|--------|--------------------|----------------------|-------------------|
| 27. Manner of Death 1 Natural 5 □ Pending | 28e. Date of Injury<br>(Month, Day Year) | 28b. Time of<br>Injury |        | Injury et<br>Work? | 28d. Describe how in | njury occurred    |

investigetion 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 3 ☐ Suicide Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 ☐ Homicide

29a. Certifier

Certifying Physicien: To the best of my knowledge, deeth occurred et the time, date and plece, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of exemination end/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner steted. (Check only one) 29d. Date signed (Month, Day, Yeer) 29c. License number 29b. Signature en title of certifier

| 30. | Napre | and | eddress | of person | who comple | ted cause | of death (Iten | 1 23e) (Type, Pr | int) |   |
|-----|-------|-----|---------|-----------|------------|-----------|----------------|------------------|------|---|
| 6   | 20    | 1 ) | (8)     | 7714      | O LAN      | 2 1       | 2070           | OLD              | LANG | < |

31. Dete filed (Month, Day, Year) 32. Registrar's Signeture

State Registrar

DFC 2 9 2005

|                   |   |                  | 1- State of Marylan  | d / Department of Health and M<br>Certificate of Death   | lental Hygien                                   | C000 41000   |
|-------------------|---|------------------|--|--|---|--|
|                   | n   |                  | Decedent's Name (First, Middle, Last)  | 24/ 12-  | 2. Date of Death                                | 3. Time of Death   |
|                   | Physici:<br>/Medic  |                  | Harry Ernest   |  | 12 -  | 7 - 05 1403M   |
| 1                 | Examin  | er               | 4a. Facility Name (If not institution, give street and number)   | 4b. City, Town, or Location of Death   | 4   | c. County of Death   |
|                   | Funeral<br>Director   |                  | FLDINSULA LEGIONAL MEDICAL LEC<br>5. Social Security Number 6. Sex 7. Age (In yrs. 2 o 9 − 0 7 − 6/88 1 M 2 □ F 9 1 M 1 M 2 M 2 M 2 M 2 M 2 M 2 M 2 M 2 M  | last birthday) Yrs.  Months Days Hours Min.  | 8. Date of Birth<br>(Month, Day, Yea            | 9. Birthplace (State or Foreign Country)                             |
|                   | land<br>ow  |                  | 10a State 10b County / 10c Cit   | y, Town or Location  |   | 10d. Inside City Limits  |
|                   | Many<br>a-f sh  | tor              | VA. Accomack   | ChincoTeague   |   | 1 ☑Yes 2 ☐ No  |
|                   | th with the<br>23a or 28  | Funeral Director | 10e. Street and Number 6382 Volcation Park Di  | 10f. Zip Code<br>23336   | 10g. C  | Citizen of What Country?<br>USA                                      |
| 5-0036            | s 1 and 2 should be filed within 72 hours atter deeth with the Maryland I Health and Mental Hygiene. Item 27 is marked other than "natural", or Items 23s or 28s-1 show other trsumatic event, the Medical Examinar must be inditted at | ρ                | 11. Marital Status  1 Never Married 2 Married  1 Never Married 2 Married  3 Widowed 4 Divorced  12. Was Decedent Ever in U. Armed Forces?  1 Yes 2 Month Yes 3 Widowed 4 Divorced  | .S. 13. Was Decedent of Hispanic Origin? (Spe<br>If Yes, specify Cuban, Mexican, Puerto I<br>1 ☐ Yes 2 ☒ No Specify: | ecify Yes or No-<br>Rican, etc.)                | 14. Race - American Indian,<br>Black, White, etc,<br>Specify: White  |
| 5-0               | 72 hc<br>'natu  | eted             | 15. Decedent's Education (Specify only highest grade completed)  | 16a. Decedent's Usual Occupation (Give kind of work done during most of worki  | ing 16b.  | Kind of Business/Industry  |
| 121               | within noe.   | Completed        | Elementary/Secondary (0-12) College (1-4or 5+)   | life. DO NOT use retired)  Steel worker  |   | USSteel  |
| d 2               | filed v<br>Hygie<br>Ather I   | e Co             | 17. Father's Name (First, Middle, Last)  | ·  | e (First, Middle, Maide                         | en Sumame)   |
| an                | Mental<br>Mental<br>arked c   | To B             | George Walker  | Annie  | Huchan  | -d Walker  |
| , Maryland        | 1 and 2 should<br>Health and Men<br>Iom 27 is marke<br>other trsumatic  |                  | 19a. Informant's Name/Relationship (Type, Print)<br>Ethel Webber Walker  | 19b. Mailing Address (Street and Number or Rura 6328 Vacation  |   |  |
| Baltimore         | Pages 1 and 3<br>ment of Health<br>ant: If Item 27<br>ary or other tra  |                  | 1 X Burial 2 Cremation 3 Removal from State  |  | Date 20c. 5                                     | Location - City or Town, State PA-                                   |
| Balti             | permit. Pages<br>Depertment of<br>Importent: If II<br>any injury or o   |                  | 21. Signature of Funeral Service Licensee  Amanda C. Botto.  | 50/yer Funeral Hom   | ~ 6327 C  | hurch 87<br>Lincot eague Va  |
|                   |   |                  | 23a. Part1. Enter the disease, or complications that caused the deat<br>shock, or heart failure. List only one cause on each line.   | h. Do not enter the mode of dying, such as cardiac o   | or respiratory arrest,                          | Approximate<br>Interval Between                                      |
| 1                 | Physician   |                  | Immediate Cause (Final disease or condition resulting in death)  | LEAGRE (ARDIOJASE  | V-AR DI   | SEMIE Onset and Death  |
| 1                 | /Medical<br>Examiner  |                  | Due to (or as a conseq   | uence of):   |   | ,  |
| 8                 |   | ē                | Sequentially list conditions, if any, leading to immediate Due to (or as a conseq  | uence of):   |   |  |
|                   | uted<br>d<br>ansit  | Examine          | cause. Enter Underlying Cause (Disease or injury that initiated events   |  |   |  |
| ó,                | e be executed<br>sicien and<br>burial-transit   | Exa              | resulting in death) Last Due to (or as a conseq  | uence of):   | ""  |  |
| 8760              | ate be ex<br>physicien<br>the buria   | dicai            | d  |  |   |  |
| Вох 68            | ding p  | /Mec             | IF FEMALE: 23c. If yes, outcome of pregna  | ancy   |   |  |
| P.O. Bo           | Physicien: The law requires that the death certificate be executed this certificate has been signed by the attending physicien and rall director, page 2 should be detached for use as the burial-transit                               | Physician/Med    | 23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No 9 Unknown   | Il death 3 ☐ Ectopic pregnancy   |   | 23d. Date of delivery  Month Day Year                                |
|                   | e that<br>ned b<br>e deta   | by PI            | Part II. Othar significant conditions contributing to death but not res  | ulting in the underlying cause given in Part I.  | 23e. Did tobacco                                | use contribute to the cause of death?                                |
| Records,          | w require<br>been sig<br>should b   | ed t             | RENAL FAILURE  |  | 1 ☐ Yes   | 2 No 3 Probably 4 Au⊓unknown   |
| ဝ၁                | law reas be   | Completed        |  |  | 24a. Was an autopsy                             | 24b. Were autopsy findings available prior to completion of cause of |
|                   | : The<br>cete h   | Соп              |  |  | performed?<br>1 ☐ Yes 2 ☑ N                     |  |
| Vita              | sector  | Be               | 25. Was case referred to medical examiner?  Hospital:  | 26. Place of Death   |   |  |
| ō                 | Phys<br>or this<br>oral di  | ı; To            | 1  Yes 2 No 103 Natural 2 No 21 Natural 5 Pending (Month, Day Year)  | 28b. Time of 28c. Injury at 2  | me 5 Residence<br>28d. Describe how in          |  |
| io                | Attending ir death. •ctor: After by the fune  | atlo             | 1 Natural 5 Pending (Month, Day Year) 2 Accident investigation   | Injury Work?  M 1 Yes 2 No   |   |  |
| Division of Vital | al or Atte<br>s atter des<br>d Directo  | Certification;   | 3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At h building, etc. (Specif   | ome, farm, street, factory, office   | 28f. Location (Street a<br>City or Town, Sta    | and Number or Rural Route Number,<br>te)                             |
|                   | To the Hospital or Attending Physicien: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2   | Medical C        | 29a. Certifier (Check only one)  12 Certifying Physicien: To the best of my knot one)  14 Certifying Physicien: To the best of my knot one one of the best of my knot one of the best of the best of my knot one of the best of the best of my knot one of the best of my knot one of the best of t | owledge, death occurred at the time, date and place, a tition and/or investigation, in my opinion, death occurred    | and due to the cause(<br>ed at the time, date a | (s) and manner as stated.<br>nd place, and due to the cause(s)       |
|                   | within to the comp  | Ž                | 29b. Signature and little of certifier   | 29c. License number  | 29d. D  | late signed (Month, Day, Year)<br>12-7-65                            |
| -                 | No.   |                  | 30. Name and address of person who completed cause of death (Item  | n 23a) (Type, Print)   |   |  |
|                   | 50  |                  | Renee Desmaris 100 E. Carrol   |  | 21801   |  |
|                   | Sta<br>Registr  |                  | 31. Date filed (Month, Day, Year) 32. Registrar's Signa DEC 0 9 2005   | Ature  |   |  |
| DH                | MH 17 Rev 1/2   | _                | V V 2003 filler  | 10. Paparer  |   |  |

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygierie For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Day Bonnie Olga Wanko December 8, 12:27 PM 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Takoma Park
Under 1 Year | If Under 24 Hrs Washington Adventist Hospital Montgomery 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) **Funeral**  Birthplace (State or Foreign Country) Days Months Hours 1 M 2 XF Min. Director 269-58-7286 65 Jan 11, 1940 Illinois Usuaf Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28e-f show other treumatic event, the Medical Examinar must be notified at Funeral Director 1 Tes 2 No Maryland Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with Itama 23a permit. Pages 1 and 2 should be filed within 72 hours after death \\
Department of Health and Mental Hygiane. \\
Important in the 27 is marked other than "naturat', or itama 23a \\
any injury go other treumatic event, the Medical Example of the the 1000. 12004 Galena Rd 20850 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 ☐ Yes 2 ▼ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 🔀 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🙀 No Completed by Specify Specify 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 0 Psychic Fortune Telling 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ဥ Pete Ristich Mary Marks 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michael Wanko/Husband 12004 Galena Rd, Rockville, MD 20850 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Washington Memorial Dec 13, 2005 Homewood, IL 22. Name and Address of Facility Hines-Rinaldi Funeral Home 21. Signature of Funeral Service Licensee Mai 11800 New Hampshire Ave, Silver Spring, MD 20904 23a. Part1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit 82 attending physicien and for use as the burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical 23c. ff yes, outcome of pregnancy
1 Live birth 2 Fetaf death 23b. Was decedent pregnant in the past 12 months?

1 Yes 22 No 9 Unknown 23d. Date of delivery 3 Ectopic pregnancy Day Year 4☐Pregnant at time of death 5 Other (specify) been signed by the s should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 Probably Aunknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe certificete 1 ☐ Yes 2 ☐ No 1 Yes No 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 atient ٩ 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA this After thi funeral of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of Certification: 28d. Describe how injury occurred 5 Pending investigation Matural Injury death. nerel Director: A 1 ☐ Yes 2 ☐ No 2 Accident 3 🗌 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, lactory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funerel [ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29d, Date signed (Month, Day, Year) Menon 1208105 2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) connoce ne 31. Date filed (Month, Day, Year) 32. Registrar's Signature State DEC 09 Registrar

DHMH 17 Rev 1/2001

Registrar

|                                       |  |                | 1 - State<br>Registrar  | State of Maryland  | / Depa<br><i>Cer</i>           | rtment of H<br>tificate of L   | ealth and<br>Death                           |  | Reg. No.                | 005   | 41638  |
|---------------------------------------|--|----------------|---|--|--------------------------------|--|--|--|-------------------------|---|--|
|                                       | Physic<br>/Medi  |                | 1. Decedent's Name (First, Middle, Last) Anthony A.   | Wrenn Jr.  |                                |  |  | 2. Date of De<br>Month<br>DECEMI           | Day                     | , 2005  | 3. Time of Death 9:37 P M                          |
|                                       | Examir   |                | 4a. Facility Name (If not institution, give s   |  | 1                              | 4b. City, Town, or   |  |  | 4c.                     | County of Death                                   |  |
|                                       | Funeral  | -              | PRINCE GEORGES HOS 5. Social Security Number 6. Sex 125   | SPITAL CENTER  7. Age (In yrs. last  27  | birthday)                      | CHEVERLY If Under 1 Year   | If Under 24 H                                | rs. 8. Date of Bir                         |                         |   | EORGES CO  |
| · · · · · · · · · · · · · · · · · · · | Director   |                |   | M 2□F 27   | Yrs.                           | Months Days  | Hours M                                      | in. 8. Date of Bir<br>(Month, Da<br>June 8 | 1978                    | 8 Wash  | place (State or Foreign<br>ptry)<br>ington, DC     |
|                                       | yland  |                | Usual Residence of Decedent  10a. State 10b. County   | 10c. City, T   |                                |  |  |  |                         | 1   | 10d. Inside City Limits                            |
|                                       | he Mar<br>8a-f si  | Director       | MD Prince Ge  | eorges Cap   | itol                           | Heights  |  |  |                         |   | 1. Yes 2 □ No                                      |
|                                       | 23e or 2   |                | 10e. Street and Number<br>215 Unicorn Place   |  |                                | 10f. Zip Code<br>20743   | 3  |  | Unit                    | zen of What Cour<br>ced State                     | ntry?<br>ES  |
| 900                                   | 72 hours after death with the Maryland<br>"naturel", or Iteme 23a or 28e-f show<br>dical Examinant be notified at  | by Funeral     | 11. Marital Status  1. XNever Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced                        | 12. Was Decedent Ever in U.S.<br>Armed Forces?<br>1 ☐ Yes 2 XNo<br>If Yes, Give<br>Year or Dates:                | 1                              | /as Decedent of His<br>Yes, specify Cubar<br>□ Yes 2X No                     | spanic Origin?<br>n, Mexican, Pu<br>Specify: | (Specify Yes or No<br>erto Rican, etc.)    |                         | 14. Race - Americ<br>Black, White,<br>Specify: B] |  |
| Baltimore, Maryland 21215-0036        | within<br>ane.<br>then   | Completed      | 15. Decedent's Educ<br>(Specify only highest grade<br>Elementary/Secondary (0-12)<br>12th         | cation 10 completed) College (1-4or 5+)  |                                | ent's Usual Occupa<br>tind of work done di<br>O NOT use retired)<br>employed | tion<br>uring most of w                      | vorking                                    |                         | nd of Business/Inc                                | dustry   |
| d 2                                   | Hygi<br>ther<br>int.   | a l            | 17. Father's Name (First, Middle, Last)   |  | UII                            | -  | 18. Mother's N                               | ame (First, Middle,                        |                         | mployed<br>Sumame)                                |  |
| ylar                                  | nould be<br>il Mental<br>narked o  | To B           | Anthony A Wrenn   |  |                                |  |  | line Brow                                  |                         |   |  |
| Mai                                   | nd 2 shallth and 27 ls m   |                | 19a. Informant's Name/Relationship (Type<br>Andia A Evans / F                                     |  | 9b. Mailing<br>2 <b>1</b> 5 U: | g Address (Street a.<br>nicorn Pl  | nd Number or .<br>.ace Caj                   | Ru <i>ral Route Numbe</i><br>pitol Hei     | er, City or<br>.ghts    | Town, State, Zip<br>MD 207                        | (Code)<br>743                                      |
| ore,                                  | Pages 1 and 2 should bent of Health and Ments in item 27 is marked by or other traumatice  |                | 20a. Method of Disposition 1∑ Burial 2 ☐ Cremation 3 ☐ Re   |  | of Dispos                      | ition (Name of<br>atory or other place                                       | )  | Date                                       | 20c. Loc                | cation - City or To                               | own, State   |
| Him                                   | T E E  |                | 4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Funeral Service License                        | Ft.  |                                | oln Cemet  |  |  |                         |   | Maryland   |
| Ba                                    | Depe<br>Impo<br>any I  |                | 2000  | >  | 22.                            | Name and Address<br>Austin R   | loyster<br>h St 1                            | Funeral<br>W Washin                        | Home                    | DC 200  | 111  |
|                                       |  |                | 23a. Part1. Enter the disease, or complice shock, or heart failure. List only on                  |  |                                | r the mode of dying  | , such as cardi                              | ac or respiratory ar                       | rrest,                  | , 10. 200   | Approximate<br>Interval Between<br>Onset and Death |
|                                       | Physician<br>/Medical  |                | Immediate Cause (Final disease or condition resulting in death)                                   | Shotgun Wo   | und                            | to isacl   | <u> </u>                                     |  |                         |   | Onsol and Death                                    |
|                                       | Examiner   | _              | Sequentially list conditions, b.  | Duarto (or as a consequenc   |                                |  |  |  |                         |   |  |
|                                       | outed<br>d   | Examiner       | Tany, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events | Dos to to as a consequent  | Jes Oi).                       |  |  |  |                         |   |  |
| 60,                                   | ficate be executed<br>physicien and<br>is the burial-transit   | al Ex          | resulting in death) Last  | Due to (or as a consequence  | ce of):                        |  |  |  |                         |   |  |
|                                       |  | ledicai        | d.  |  |                                |  |  |  |                         |   |  |
| .O. Box                               | the death certiff the attending ched for use as  | Physician/M    | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown           | 3c. If yes, outcome of pregnancy<br>1 ☐ Live birth 2 ☐ Fetal dea<br>4 ☐ Pregnant at time of death<br>9 ☐ Unknown |                                | Ectopic pregnancy<br>Other (specify)   |  |  | 23                      | 3d. Date of delive<br>Month                       | ry<br>Day Year                                     |
| <u>α</u>                              | w requires that the de<br>been signed by the<br>should be detached   | þ              | Part II. Other significant conditions cont  | ributing to death but not resulting  | j in the und                   | derlying cause giver   | n in Part I.                                 | 23e. Did to                                |                         | /   | e cause of death?                                  |
|                                       | 2 2 2  | Completed      |   |  |                                |  |  | 24a. Was autop<br>perfor<br>1 Yes          | sy                      | prior to con<br>death?                            | osy findings available apletion of cause of        |
| Ž.                                    | or Attending Physician: after death. Director: After this certific in by the funeral director.   | o Be           | 25. Was case referred to medical examiner? 1∑ Yes 2 □ No  | ospital: 1 ☐ Inpatient 2 ☐ ER/0  | Outpatient                     | 3□ DOA Other   |  | eath <i>Check only of</i> Home 5 Resid     |                         | MOther (Specific                                  | SCENE  |
| 0 0                                   | ing Ph<br>After th<br>uneral   | on: T          | 27. Manner of Death 1 □Natural 5 □ Pending  | 28a. Date of Injury 28b  | . Time of                      | 28c. Injury a<br>Work?   | at   | 28d. Describe h                            |                         |   | / DOBLINE  |
| /isio                                 | Attend<br>death<br>ctor: /   | Certification: | 2 Accident investigation 3 Suicide 6 Could not be determined                                      | 28e. Place of Injury - At home,  | farm, stree                    |  | es 2 No                                      | SUN 3                                      | ect                     | Shot Number of Bural                              | Route Number                                       |
| á                                     | To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: Atter this certificate ha completely filled in by the funeral director, page |                | 4 Zanorinicide  | Local S  | tree                           | <del></del>  |  | 1 60 3110                                  | -1 17-2                 | Number or Rural<br>213 Un 1<br>219Uts H           | D  |
|                                       | To the Hospital within 24 hours a To the Funerel completely filled   | edicai         | 29a. Certifier (Check only one)   | cian: To the best of my knowled<br>er: On the basis of examination a<br>and manner stated.                       | ge, death o<br>and/or inve     | occurred at the time<br>stigation, in my opir                                | , date and place<br>nion, death occ          | e, and due to the curred at the time, o    | ause(s) a<br>late and p | and manner as sta<br>place, and due to            | ated.<br>the cause(s)                              |
| )                                     | 1  | Σ              |   | lan ma   |                                | O C M  |  |  |                         | signed (Month, E<br>MBER 8,                       |  |
|                                       |  |                | 30. Name and address of person who com  | npleted cause of death (Item 23a   |                                | int)<br>11 PENN S  | STREET,                                      | BALTIMOR                                   | E, M                    | ARYLAND,  | 21201  |
|                                       | Sta<br>Registra  |                | 31. Date filed (Month, Day, Year)   | 32 Registrar's Signature   | None .                         | W  |  |  |                         |   |  |

JOSEPH M. WALSH 05-08139 RJ

| <i>/</i> 01.    | <b>3</b> ,   |                  | 1 - For<br>Stete<br>Registrer  | State of Maryla  |                           | artment o                            |                              | nd Mental Hy                                  | giene (          | )5                     | 41639  |  |  |
|-----------------|--|------------------|--|--|---------------------------|--------------------------------------|------------------------------|---|------------------|------------------------|--|--|--|
|                 | D  |                  | 1. Decedent's Name (First, Middle,   | Last)  | -                         |                                      | -                            | 2. Date of De<br>Month                        | eath<br>Day      | V                      | 3. Time of Death                                   |  |  |
|                 | Physici<br>/Medio  |                  | Joseph   | Michael  | W                         | alsh                                 |                              | Decemb  | er 2, 2          | 005                    | 10:05 p.M  |  |  |
|                 | Examir   |                  | 4a. Facility Name (If not institution,   |  |                           | 4b. City, Tow                        | n, or Location of            | Death   | 4c. Count        | ty of Death            |  |  |  |
|                 |  |                  | 3221 S. Leisure  | World Boulevar   | rd.                       | Si1                                  | ver Spr                      |   | Mont             | gomer                  | y County   |  |  |
|                 | Funeral  |                  | 1  | S. Sex 7. Age (In yrs  |                           | Months Da                            | ear If Under 2<br>ays Hours  | 4 Hrs. 8. Date of Bi<br>Min. (Month, D.       | rth              |                        | place (State or Foreign ntry)                      |  |  |
|                 | Director   |                  | 209 14 9619  | 80   | Yrs.                      |                                      |                              |   | 7, 1925          | 1925 Pennsylvania      |  |  |  |
|                 | and w  |                  | Usual Residence of Decedent  10a. State 10b. County  | 10c. C   | ity, Town or L            | ocation                              |                              |   |                  |                        | 10d. Inside City Limits                            |  |  |
|                 | Aaryl<br>f • ho  | 5                | Ma11 W .   |  |                           |                                      |                              |   |                  |                        | 1 ☐ Yes 2 No                                       |  |  |
|                 | 28a-   | ect              | Maryland Mont  | gomery Si  | lver S                    | pring<br>10f. Zip Cod                | 40                           |   | 10g. Citizen of  | M/hat Cau              |  |  |  |
|                 | with   | Funeral Director | 3221 South Leisu   | ro World Divd  | #2D                       |                                      |                              |   |                  |                        | ntry t   |  |  |
|                 | ns 23  | era              | 11. Marital Status   | 12. Was Decedent Ever in U   |                           |                                      | 20906                        | in? (Specify Ves or N                         |                  | JSA                    | can Indian.  |  |  |
|                 | fer d  | E                | 1 Never Married 2 Marrie   | Armed Forces?  |                           | If Yes, specify (                    | Cuban, Mexican,              | in? (Specify Yes or No<br>Puerto Rican, etc.) | Bla              | ck, White,             |  |  |  |
| 036             | urs a  | þ                | 3 Widowed 4 Divorced   | If Yes, Give<br>Year or Dates:   |                           | 1 ☐ Yes 2 🙀                          | No Specify:                  |   | Speci            | γ: <b>W</b>            | hite   |  |  |
| 21215-0036      | within 72 hours after death with the Maryland<br>ene.<br>then "naturet", or items 23e or 28e-f ehow<br>he Masilisal Exeminar must be notillised at   | Completed        | 15. Decedent's   | Education  |                           | dent's Usual Oc                      |                              |   | 16b. Kind of E   | dusiness/In            | dustry   |  |  |
| 215             | nin 7  | pje              | (Specify only highest<br>Elementary/Secondary (0-12)   | College (1-4or 5+)   | life.                     | DO NOT use re                        | one during most (<br>stired) | of working                                    |                  |                        |  |  |  |
| 21              | d wit  | ĕ                | , (  | 5+   |                           | Attor                                | ney                          |   | U.S. (           | overi                  | ment   |  |  |
| g               | be filed<br>tai Hygi<br>d other  | Be (             | 17. Father's Name (First, Middle, La   | est)   |                           |                                      | 18. Mother                   | s Name (First, Middle                         |                  |                        |  |  |  |
| /la             | should bind Ment   | ည                | Michael F. Wals  | n  |                           |                                      | Este1                        | la Ryan                                       |                  |                        |  |  |  |
| Maryland        | 01 00 -  |                  | 19a. Informant's Name/Relationship   | (Type, Print)  | 19b. Maili                | ng Address (Str                      | reet and Number              | or Rural Route Numb                           | er, City or Town | , State, Zir           | Code)  |  |  |
|                 | 1 and 2<br>Heelth<br>em 27   |                  | Timothy Walsh /  | Son  | 1113                      | Tanley                               | Road Si                      | lver Sprin                                    | o Merv           | land                   | 20904  |  |  |
| Baltimore,      | 0 0 1/-  |                  | 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3  | į.   | Hace of Dispi             | osition (Name of<br>matory or other  |                              | Date  | oc. Location     | - City or To           | own, State   |  |  |
| Ĕ               | permit. Pages Depertment of I Important: If It important: If It in portant in proces   |                  | 4 Donation 5 Other (Spe  | city Ga  |                           |                                      |                              |   |                  |                        | ng, Maryland                                       |  |  |
| alt             | permit. Depertrimportri |                  | 21. Signature of Funeral Service Lic   | nsee   |                           |                                      |                              |   |                  |                        |  |  |  |
| <u> </u>        | 89 E 2 9   |                  | 21. Signature of Funeral Service Lionsee  22. Name and Address of Facility Hines Rinaldi Funeral 11800 New Hampshire Ave Silver Spring                     |  |                           |                                      |                              |   |                  |                        |  |  |  |
|                 | Physician<br>/Medical<br>Examiner  |                  | 23a. Part1. Enter the disease, or or shock, or heart failure. List or immediate Cause (Final disease or condition resulting in death)                      | aDue to (or as a consec  | nhal                      |                                      | -                            | ardiac or respiratory a                       | 0                | 201                    | Approximate<br>Interval Between<br>Onset and Death |  |  |
| ,8760,          | death certificate be executed etitlending physicien and ad for use as the burial-transit   | dical Examiner   | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | cDue to (or as a consec  |                           |                                      |                              |   |                  |                        |  |  |  |
| P.O. Box 6      | it the death certifica<br>by the ettending ph<br>tached for use as t   | Physician/Mec    | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No   | 23c. If yes, outcome of pregn. 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of c | aldeath 3[                | ⊒Ectopic pregna<br>☐ Other (specify) | ancy                         |   |                  | ate of delive          | ery<br>Day Year                                    |  |  |
| S,              | iaw requires that the<br>es been signed by th<br>2 should be detache   | by P             | Part II. Other significant conditions  | contributing to death but not res  | sulting in the u          | nderlying cause                      | given in Part I.             | 23e. Did t                                    | obacco use con   | inbute to th           | ne cause of death?                                 |  |  |
| ğ               | quire<br>an sig<br>uld b   |                  |  |  |                           |                                      |                              | 10  | Yes 2 □ No       | 3 Prob                 | ably 4 Dunknown                                    |  |  |
| of Vital Record | s been s   | Completed        |  |  |                           |                                      |                              | 24a. Was                                      | an 24b.          | Were auto              | psy findings available                             |  |  |
| æ               | The lav  | E                |  |  |                           |                                      |                              |   | rmed?            | prior to con<br>d-ath? | mpletion of cause of                               |  |  |
| ta              | en:<br>tifice<br>for, p  | 0                | 25. Was case referred to medical   |  |                           |                                      | 26 Place o                   | 1 Death   Check only o                        |                  | 1 Yes                  | 2□ No  |  |  |
| i>              | Physicien:<br>this certific<br>ral director,   | ToB              | examiner?<br>1∑Yes 2 □ No  | Hospital: 1 Inpatient 2  | FR/Outpatier              | 3 7 7004                             | Othor                        | ing Home 5 Resid                              |                  | 05 (0556)              | . At acom-   |  |  |
|                 | er thi   |                  | 27. Manner of Death  | 28a. Date of Injury  | 28b. Time of              |                                      | njury at<br>Nork?            |   | now injury occur |                        | ) At scene   |  |  |
| Ö               | Attending<br>ir deeth.<br>ector: Aftel<br>by the fune  | 읉                | 1 ☐ Natural 5 ☐ Pending<br>2 🗷 Accident investigat   | ion (Month, Day Year)  | Forma farm str            | - ρι 1                               | Nork?<br>□Yes 2⊅(No          | Victor  | mofh             | euse                   | five.  |  |  |
| Division        | al or Attending P<br>s efter deeth.<br>i Director: After I<br>d in by the funera   | Certification;   | 3 Suicide 6 □ Could not<br>4 □ Homicide determine  | be 28e. Place of Injury - At h   |                           | eet, factory, offic                  |                              | 28f. Location (5                              | Street and Numb  |                        |  |  |  |
| Ö               | e Hospital or<br>124 hours efte<br>e Funeral Dire<br>letely filled in L  | er               | 4   Homicide   | building, etc. (Special  | iville                    | Anut                                 | MANA                         | City or Tov                                   | vn, State) 33    |                        | Leisure 300109 MD                                  |  |  |
|                 | 10 0 0 E   | ie i             | 29a. Certifier 1 Certifying  | Physicien: To the best of my kno   | wiedge, death             | occurred at the                      | e time, date and             | place, and due to the                         | cause(s) and ma  | 22225                  | -1-4   |  |  |
|                 | To the Hos<br>within 24 h<br>To the Fur<br>completely  | edicai           | (Check only XX Medical Ex  | aminer: On the basis of examina<br>and manner stated.                            | ition and/or in           | vestigation, in m                    | y opinion, death             | occurred at the time,                         | date and place,  | and due to             | the cause(s)                                       |  |  |
|                 | To the<br>within 2<br>To the<br>complet  | ž                | 29b. Signature and title of certifier  | 1  |                           |                                      | ense number                  |   | 29d. Date signe  |                        |  |  |  |
|                 | 1  |                  | (arro  | Hallann  | vd                        | OC                                   | CME                          |   | December         | c 3, :                 | 2005   |  |  |
|                 | 15   |                  | 30. Name and address of person wh  | o completed cause of death (Iter   | n 23a) (Type,             | Print) 111                           | Penn Str                     | reet Ralt                                     | imore 1          | Marul                  | and 21201  |  |  |
|                 |  |                  | CAROL H.   | AZLAN)   |                           |                                      | - CIHI DU                    | LCCC Dart                                     | more, I          | тат ут                 | AIR 21201  |  |  |
|                 | Sta<br>Registr   |                  | 31. Date filed (Month, Day, Year)  | 32. Registrar's Signa  | 32. Registrar's Signature |                                      |                              |   |                  |                        |  |  |  |

| ) <b>)</b> 2                   | <i>- 1</i>  |                               | Unpend item  | 23a,27,28a-f<br>6 State of Ma  | perME 6851<br>ryland / De           | 1713<br>partn                | nent of H   | ealth a                                  | nd M                     | ental Hyg                            | iepe() ()  | 5  | 1640                                      |  |               |                  |            |                 |
|--------------------------------|---|-------------------------------|--|--|-------------------------------------|------------------------------|---|--|--------------------------|--------------------------------------|--|--|---|--|---------------|------------------|------------|-----------------|
|                                |   |                               | 1 State Registrar  1. Decedent's Name (First, Middle, La.  |  | Ce                                  | ertific                      | cate of L   | Death                                    |                          |                                      | eg. No.  |  |   |  |               |                  |            |                 |
|                                | Physici<br>/Medic   |                               | Kevin Michael Warehime   |  |                                     |                              |   |  |                          | Day                                  | Year<br>005                                      | 3. Time of Death 9:58 A M                                  |   |  |               |                  |            |                 |
|                                | Examir  |                               |  |  |                                     |                              |   |  |                          | 4c. County                           | of Death   |  |   |  |               |                  |            |                 |
|                                | Funeral   |                               | Social Security Number 6. S  | ex 7. Age  | (In yrs. last birthda               | /) If L                      | Jnder 1 Year                                      | If Under 2                               | 4 Hrs.                   | 8. Date of Birth<br>(Month, Day,     |  | Baltimore County  9. Birthplace (State or Foreign Country) |   |  |               |                  |            |                 |
|                                | Director  |                               | 213-17-3520 Usual Residence of Decedent  | <b>⊠</b> M 2□F   | 18 Yrs.                             | Mor                          | nths Days   | Hours                                    | Min.                     | April 1                              | .6 1987  | Coun   | MD  |  |               |                  |            |                 |
|                                | show<br>ad at   | 5                             | 10a. State 10b. County 10c. City, Town or Location Westminster   |  |                                     |                              |   |  |                          | Od. Inside City Limits               |  |  |   |  |               |                  |            |                 |
|                                | r 28a-f   | rect                          | 10e. Street and Number   | <u>'</u>   | Wesular.                            |                              | f. Zip Code                                       |  |                          | 10                                   | Og. Citizen of W                                 | hat Coun   | 1 ☐ Yes 2 🛣 No                            |  |               |                  |            |                 |
|                                | 23a o   | rai D                         | 516 Old Baltimor   | re Road  |                                     |                              |   | 157                                      |                          |                                      | US   |  |   |  |               |                  |            |                 |
| <b>'</b>                       | fler de   | Fune                          | 11. Marital Status 1 X Never Married 2  Married  | 12. Was Decedent E<br>Armed Forces?<br>1 ☐ Yes 2 🔀 N                   |                                     | . Was D                      | Decedent of His<br>specify Cubai                  | spanic Origi<br>n, Mexican,              | in? (Spec<br>Puerto R    | ify Yes or No-<br>ican, etc.)        | 14. Race<br>Black                                | · Americ<br>, White, e                                     |   |  |               |                  |            |                 |
| 3036                           | 72 hours after death with the Maryland<br>natural; or Items 23a or 28a-f show<br>Acal Examiliner in wat be notified at  | Completed by Funeral Director | 3 Widowed 4 Divorced Year or Dates:  |  |                                     |                              | 1 ☐ Yes 2X No Specify:                            |  |                          |                                      | Specify: White                                   |  |   |  |               |                  |            |                 |
| 15-(                           | in 72 h<br>n *natu  | piete                         | 15. Decedent's Ed<br>(Specify only highest gra   | de completed)  | (Giv                                | edent's<br>e kind o<br>DO NO | Usual Occupa<br>of work done d<br>OT use retired) | tion<br>uring most o                     | of working               | 9                                    | 6b. Kind of Bus                                  | iness/Ind  | ustry                                     |  |               |                  |            |                 |
| 212                            | ed with<br>rgiene.<br>ier thei  | Com                           | Elementary/Secondary (0-12) College (1-4or 5+)  12 Student   |  |                                     |                              |   |  |                          | Education                            |  |  |   |  |               |                  |            |                 |
| and                            | ntel Hy   | Be                            | 17. Father's Name (First, Middle, Last)  |  |                                     |                              |   |  |                          |                                      | laiden Surname                                   | )  |   |  |               |                  |            |                 |
| ary                            | should<br>and Me<br>a mark<br>umatic  | ٦<br>ک                        | Michael E. Wareh  19a. Informant's Name/Relationship (1)   |  | 19b. Mai                            | ling Add                     | dress (Street a                                   |  |                          | rol Sch<br>Route Number,             | City or Town, S                                  | tate. Zip  | Code)                                     |  |               |                  |            |                 |
| Ž,                             | and 2<br>ealth a<br>m 27 is   |                               | Michael E. Warehi  | me/Father  | 516                                 | Old                          | d Balti   | more :                                   |                          |                                      | inster,  |  | 21157                                     |  |               |                  |            |                 |
| Baltimore, Maryland 21215-0036 | permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Depertment of Health and Mentlel Hygiene. Important: if Item 27 is marked other then "natural; or Items 23a or 28a-f show enty injury or other traumatic event, the Madical Examiner must be notified at ODGs. |                               | 20a. Method of Disposition  1 □→Burial 2 □ Cremation 3 □  4 □ Donation 5 □ Other (Specify  | Removal from State   | 20b. Place of Disp<br>cemetery, cri |                              |   |  | Da<br>2/21               |                                      | Smallwo  |  |   |  |               |                  |            |                 |
|                                | permit. Depertr Imports eny inju  |                               | 21. Signature of Funeral Service Licen   | See  |                                     | 2. Nam<br>P <b>ri</b> t      | e and Address                                     | s of Facility<br>eral                    | Home                     | and Ch                               | apel, P  | .A.  | 21157                                     |  |               |                  |            |                 |
|                                |   |                               | 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  Approximate Interval Between  |  |                                     |                              |   |  |                          |                                      |  |  |   |  |               |                  |            |                 |
| j                              | Physician<br>/Medical   |                               | Immediate Cause (Final disease or condition resulting in death)  | 4.   | Intoxicatio                         | n                            |   |  |                          |                                      |  |  | Onset and Death                           |  |               |                  |            |                 |
|                                | Examiner  |                               | - 1  |  | consequence of):                    |                              |   |  |                          |                                      |  |  |   |  |               |                  |            |                 |
|                                | ed sit  | iner                          | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated evenits c.  |  |                                     |                              |   |  |                          |                                      |  |  |   |  |               |                  |            |                 |
| o,                             | cate be executed<br>physicien and<br>the burial-transit   | Examiner                      | that initiated events c  |  |                                     |                              |   |  |                          |                                      |  |  |   |  |               |                  |            |                 |
| 8760,                          | ate be<br>hysicie<br>the bur  | Ical                          | d  |  |                                     |                              |   |  |                          |                                      |  |  |   |  |               |                  |            |                 |
| Box 6                          | certific<br>nding p   | √Med                          | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2   No 9   Unknown   23c. If yes, outcome of pregnancy   1   Live birth   2   Fetal death   3   Ectopic pregnancy   4   Pregnant at time of death   5   Other (specify)   9   Unknown   9 |  |                                     |                              |   |  |                          | and Date                             | 23d. Date of delivery                            |  |   |  |               |                  |            |                 |
| P.O. Bo                        | he death<br>the ette  | Physician/M                   |  |  |                                     |                              |   |  |                          |                                      | Month Day Year                                   |  |   |  |               |                  |            |                 |
| ď.                             | is that t   | þ                             | y Ph   | y Ph   | y Ph                                | y Ph                         | y P   | Part II. Other significant conditions co | entributing to death but | not resulting in the                 | underlyı   | ng cause giver   | n in Part I.                              |  | 23e. Did toba | acco use contrib | ute to the | cause of death? |
| ord                            | require<br>een sig<br>hould t   |                               |  |  |                                     |                              |   |  |                          | 1 ☐ Yes                              | 2 <b>D</b> No 3                                  | 2 No 3 Probably 4 Unknown                                  |   |  |               |                  |            |                 |
| Il Records,                    | Il or Attending Physicien: The law requires that the death certificate be executed after death.  Director: After this certificate has been signed by the ettending physicien and din by the funeral director. page 2 should be detached for use as the burial-transit.                            | Completed                     |  |  |                                     |                              |   |  |                          | 24a. Was an<br>autopsy<br>performe   | ed? de   | ortocom<br>ath/?   | sy findings available pletion of cause of |  |               |                  |            |                 |
| Division of Vital              | sicion:<br>certific<br>irector.   | Be                            | 25. Was case referred to medical examiner?   | Hospital:  |                                     |                              | 04-   |  |                          | Check only one,                      | )  |  |   |  |               |                  |            |                 |
| ם ר                            | ig Phya<br>ler this<br>neral di   | n: To                         | 1 Inpatient 2 EH/Outpatient 3 DOA 4 Nursing Home 5 Resi  |  |                                     |                              |   |  |                          |                                      | dence 6 □Other (Specify) how injury occurred unk |  |   |  |               |                  |            |                 |
| Sior                           | tendir<br>Jeath.<br>tor: Af<br>the fur  | catic                         | 2 ☐ Accident winvestigation 12/17/05 9:00 A M 1 ☐ Yes XX No  |  |                                     |                              |   |  |                          |                                      |  |  |   |  |               |                  |            |                 |
| N<br>O                         | ital or Al  | Certification:                | 3 ☐ Suicide 6 € Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  Found: private dwelling 28f. Location (Street City or Town, Street)  Baltimore Coulding (Street City or Town, Street)  |  |                                     |                              |   |  | ounty, MD                | +                                    |  |  |   |  |               |                  |            |                 |
|                                | To the Hospital of within 24 hours at To the Funeral D completely filled in   | edicai                        | 29a. Certifier (Check only one)  1 Certifying Phy 2 Medical Exam   | rsician: To the best of<br>iner: On the basis of e<br>and manner state | xamination and/or in                | h occur<br>ivestiga          | red at the time<br>tion, in my opin               | , date and p<br>nion, death o            | occurred                 | d due to the cau<br>at the time, dat | se(s) and mann<br>e and place, and               | er as star   | red.<br>he cause(s)                       |  |               |                  |            |                 |
|                                |   | Σ                             | 29b. Signature and title of certifier  | h - ( Il 00  | 4.0                                 |                              | 29c. License                                      |  |                          |                                      | d. Date signed (                                 |  |   |  |               |                  |            |                 |
| 7                              | MZ  |                               | 30. Name and address of person who c   | ompleted cause of dea  | ath (Item 23a) (Type                | Print)                       | O.C.M.  |  |                          |                                      | cember   |  | 2005                                      |  |               |                  |            |                 |
|                                | -CA-  | 2                             | MARGARIN D.  31. Date filed (Month, Day, Year)   | KOREW<br>32. Registrar   | 111 Pe                              | nn                           | Street,   | Balt                                     | imor                     | e, Mary                              | land 2   | 1201   |   |  |               |                  |            |                 |
|                                | Stat<br>Registra  | ~                             | DEC 2 0  |  | s signature                         | La                           | a dep to  |  |                          |                                      |  |  |   |  |               |                  |            |                 |

|                                |   |  | 1 - For State Registrar   | State of Ma   | ıryland                    | -   | artment<br>rtificate   |  |  | and M   | lental Hy   | giene<br>Reg. No.   | 005  |  | 1641   |                                 |
|--------------------------------|---|--|---|---|----------------------------|---|--|--|--|---|---|---|--|--|--|---------------------------------|
| ر                              | Physici<br>/Medic   |  | 1. Decedent's Name (First, Middle, Las<br>CHARLOTTE   | t)  | YOUNKER                    |   |  |  | 2. Date of De<br>Month<br>DECEMB   | Day<br>ER 10  | 20  | ear<br>oos  | 3. Time of Death   |  |  |                                 |
|                                | Examir  | er   | 4a. Facility Name (If not institution, give   |   | \ \ .                      |   |  |  | Location o   | f Death   |   |   | County of  |  | City   |                                 |
|                                | Funeral<br>Director   |  | 5. Social Security Number 6. S  | PKINS HOST<br>ex 7. Age<br>M 2XF  | (In yrs. las               | t birthday)<br>Yrs.   | If Under<br>Months   |  | If Under:  | 24 Hrs.<br>Min.                                     | 8. Date of Bir<br>(Month, Day<br>May 9,   | rth<br>ay, Year)  | 9  | . Birthpl<br>Count                         | ace (State or Foreign  |                                 |
| Baltimore, Maryland 21215-0036 | permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Importent: If item 27 is marked other than "naturel", or items 23e or 28e-f show any injury or other treumatic event, the Medical Exertinative Inclified at 2000.   | To Be Completed by Funeral Director  | Usual Residence of Decedent  10a. State  10b. County  Maryland  Washing  10e. Street and Number  17301 Diane Drive  11. Marital Status  1 Never Married  3 Widowed 4 Divorced  (Specify only highest grave)  Elementary/Secondary (0-12)  10  17. Father's Name (First, Middle, Last)  Amos  19a. Informant's Name/Relationship (  Steven A. Younker  20a. Method of Disposition  1 Burial 2 Cremation 3 Charles of the County of the | 12. Was Decedent II Armed Forces? 1   Yes 2   Yes   If Yes, Give   Year or Dates: ducation College (1-4or 5)  Type, Print) - Son  | Hag Ever in U.S. lo  H ine | 113.  16a. Dece (Give life.  HOU  19b. Mailii  1132  ce of Disponetery, cree  khead | WIN  101. Zip  21  Was Deced If Yes, spec  1 Yes 2  dent's Usua kind of wor DO NOT us  Sew i fo  and Address  4 Home Ceme  2. Name and | 740 lient of History Cuban lifty Cuban lif | Specify:  Ition uning most  18. Mothe Doro and Number ad Dr  11  S of Facilities | r's Name<br>thy<br>thy<br>r or Rura<br>i ve<br>2-13 | ecity Yes or Ni<br>Rican, etc.)  ing  e (First, Middle Alice al Route Numb Big Date 5-2005 sborne | 10g. Citiz  USA  Do- 1  16b. Kir  HC  A Maiden  Toms  Pool, 20c. Loe  Big | 14. Race - Black, Specify: \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ | America<br>White, a<br>Whit it<br>ness/Ind | od. Inside City Limits  1 □ Yes 2 ☑ No try?  an Indian, etc.  e ustry  Code)  wn, State  y land  |                                 |
|                                | The law requires that the death certificate be executed THE will be secured to the secure of the secure | Physician/Medical Examiner   | dicai   | 23a. Part 1. Enter thy disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Securately is condition if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that intitated events resulting in death) Last | a. HEA                     | RT Fr<br>a conseque<br>ONAR)<br>a conseque  | ALLUR ince of):  ART   | E  |  |   |   |   |  |  |  | Onset and Death  i DA y  300AYS |
|                                |   |  |   | Physician/Me  | Physician/Me               | Physician/Me  | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   | 23c. If yes, outcome<br>1 □ Live birth<br>4 □ Pregnant at<br>9 □ Unknown   | 2 Fetal d  | leath 3[<br>th 5[                                   | □Ectopic pr<br>□ Other (sp  | ecify)  |  |  | ana Did  |                                 |
|                                | w requires that<br>been signed<br>should be del   | A CONTRACTOR OF THE CONTRACTOR |   |   |                            |   |  |  | Yes 2 [  | ,   |   |   |  |  |  |                                 |
| of Vital Records,              | Physician:<br>this certifica<br>al director, p  | Completed  |   |   |                            |   |  |  |  |   | 24a. Was<br>auto<br>perf<br>1 Yes   |   | prio   | re autor<br>or to con<br>oth?<br>Yes       | osy findings available of the control of the contro |                                 |
| on of Vita                     |   | ation: To Be   | 25. Was case referred to medical examiner?  1  Yes 2 No  27. Manner of Death  1 Natural 5 Pending 2 Accident investigatio   | 28a. Date of Inju<br>(Month, Day  | nt 2□Ei<br>ry 2<br>y Year) | R/Outpatie<br>8b. Time o<br>Injury  |  | 8c. Injury<br>Work   | 9r: 4 □ Nu   | ırsing Ho   | n <i>(Check only</i><br>me 5 ☐ Res<br>28d. Describe   | idence 6  |  |  | ')   |                                 |
| Division                       | To the Hospitel or Attending is within 24 hours after death.  To the Funerel Director: After completely filled in by the funer  | 27. Manner of Death  1  Natural  2  Accident  3  Suicide  4  Homicide  28a. Date of Injury (Month, Day Year)  28b.    28b.    28c. Place of Injury - At home, far building, etc. (Specify)   |   |   |                            | ne, farm, st  | reet, factory, office 28f. Location (Stree City or Town, S   |  |  |   |   |   | or Rura  | l Route Number,                            |  |                                 |
|                                | To the Hospitel within 24 hours a To the Funerel I completely filled  | Medical  | (Check only 2 Medical Exal  | nysician: To the best<br>niner: On the basis of<br>and manner sta   | examination                |   | nvestigation,  | , in my op   | oinion, dea  |   |   | , date and  | place, and   | d due to                                   | the cause(s)   |                                 |
| 5                              | 0   | 2  | 29b. Signature and title of certifier  Sn Sutto 1   | 7.0,  |                            |   | 290  | : License<br>RES   | - 000  |   |   |   | e signed (i<br>EmBER   |  | Day, Year)   |                                 |
| C                              | 12  |  | 30. Name and address of person who  |   | leath (Item 2              | , , , , ,   |  |  |  |   | 00 E  |   |  | 212  |  |                                 |
|                                | St<br>Regist  | ate<br>rar   | 31. Date filed (Month, Day, Year)   | 32 Asgistr  |                            |   | 3 1 1 NE   | 1-1  | 1314   | VIII  | ORE, M  | HUAF  |  | aid  | - 0 /  |                                 |

ORIGINAL

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 4a per DVR, G850 12/2//05dhb

Certificate of Death

Ragino Rag. No.U 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Addison Month **Physician** December 26, 2005 2:30 PM /Medical give street and number) 4a. Facility Name 4b. City, Town, or Location of Death 4c. County of Death Examiner rowson timore If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Numb 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** Days Min. 215-28-444 Usual Residence of Decedent 1 ☐ M 2 👿 F Months Hours Director 3 the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limit **Worle** other traumatic event, the Madical Examiner must be notified at MD arkuill 1 Yes 2 No Director more 28a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 463 or Itema 23a Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Armed Forces? Black, White, etc. ☐Yes 2 No 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 Yes 202 No Specify. þ Yes. Give 3 Widowed 4 □ Divorced Year or Dates: "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry then College (1-4or 5+) filed withi Hygiene. Elementary/Secondary (0-12) ges 1 and 2 should be filed to tof Health and Mental Hygie if Item 27 is marked other it 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Bural Route Number, City or Town, State, Zip Code) auvence Addison 4628 HARRIS HUZ BRYLAND 20a. Method of Disposition
1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If Ite
any injury or ott Baltimore 4 ☐ Donation 5 ☐ Other (Specify) orraine rark maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Evans chopal of memorias 8800 Harford Parkville mo 212 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Reneil disease or condition resulting in death) Years /Medical Due to (or as a consequence of): Examiner MBETES Sequential / list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner use as the burial-transit resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1□Live birth 2 □ Fetal death 23b. Was decedent pregnant in the past 12 honths?
1 Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performen? Yes 20 No I ☐ Yes 2 ☐ No 1 ☐ Yes or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: Injury at Work? After 1 Natural 2 Accident 5 Pending within 24 hours after death. To the Funeral Director: A investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 158303 December 27 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6601 N. Charles ST Browne up 21204 Charles MD 32. Registrar's Signature 31. Date filed (Month, Day, Year)
DEC 2 State 2005 Registrar

AFF

|                |   |                               | 1 - State<br>Registrar  | State of Maryland / Dep<br>Ce   | artment of Health and rtificate of Death  | , ,   | piene 05 41643  |   |       |       |       |                           |            |  |  |  |
|----------------|---|-------------------------------|---|---|---|---|---|---|-------|-------|-------|---------------------------|------------|--|--|--|
| ą.             | Physici   | an                            | 1. Decedent's Name (First, Middle, Last) PATRICIA A   | ATILIA  |   | 2. Date of Deat<br>Month                                | Day Year 2 -2 - 0   |   |       |       |       |                           |            |  |  |  |
|                | /Medic  | al                            | 4a. Facility Name (If not institution, give s   | RTHUR  treet and number)  | 4b. City, Town, or Location of Dea  | DECEMBE   | 4c. County of Death   |   |       |       |       |                           |            |  |  |  |
| 4,0            |   |                               |   | SPITAL  | BALTIMO   | •   |   |   |       |       |       |                           |            |  |  |  |
|                | Funeral Director  |                               | 5. Social Security Number 6. Sex 15-31-6516   | 7. Age (In yrs. jast birthday,  | If Under 1 Year   If Under 24 Hrs<br>  Months   Days   Hours   Min                    |   | 9. Birthplace (State or Foreign<br>Country)                             |   |       |       |       |                           |            |  |  |  |
|                | and   |                               | Usual Residence of Decedent  10a. State 10b. County   | 10c. City, Town or L  | ocation   |   | 10d. Inside City Limits   |   |       |       |       |                           |            |  |  |  |
|                | B Mary  | ctor                          | MD.   | BALTI   | MORE  |   | 1 Yes 2 No  |   |       |       |       |                           |            |  |  |  |
|                | with the  | Dire                          | 10e. Street and Number  | Di  | 10f. Zip Code   | 1   | 0g. Citizen of What Country?  |   |       |       |       |                           |            |  |  |  |
|                | death   | nera                          | 10 - 01 100   | 12. Was Decedent Ever in U.S. Armed Forces?   | Was Decedent of Hispanic Origin? (If Yes, specify Cuban, Mexican, Pue                 | Specify Yes or No-                                      | 14. Race - American Indian,<br>Black, White, etc.                       |   |       |       |       |                           |            |  |  |  |
| 36             | within 72 hours after death with the Maryland<br>ene.<br>than "natural", or items 23e or 28e-f show<br>ta Madical Exemire must be notified at | Completed by Funeral Director | 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced  | 1 Yes 2 No If Yes, Give Year or Dates:  | 1 ☐ Yes 2 No Specify:   | no moan, etc.)  | Specify:  |   |       |       |       |                           |            |  |  |  |
| 2-00           | 72 hou<br>natura  | eted                          | 15. Decedent's Edu<br>(Specify only highest grade   | cation 16a. Dece  | dent's Usual Occupation<br>a kind of work done during most of wo                      | orkina  | 16b. Kind of Business/Industry  |   |       |       |       |                           |            |  |  |  |
| 21215-0036     | within<br>ene.<br>than  | ompi                          | Elementary/Secondary (0-12)   | College (1-4or 5+)  | DO NOT use retired)   |   | RANKING   |   |       |       |       |                           |            |  |  |  |
|                | be filed<br>stal Hygid<br>od other<br>svent, ti   | Be C                          | 17. Father's Name (First, Middle, Last)   | 1 0 0 0 0 0 0   | 18. Mother's Na   | me (First, Middle, I                                    | Maiden Surname)   |   |       |       |       |                           |            |  |  |  |
| Maryland       | should bud Ment<br>marked   | 2                             | JEFFREY EDU  19a. Informant's Name/Relationship (Ty)  | ARD BRIGGS SA   | ing Address (Street and Number or F   | ME HU   | TCHINS  City or Town State Zin Code)                                    |   |       |       |       |                           |            |  |  |  |
|                | es 1 and 2<br>of Health a<br>l Item 27 is<br>r other trau   |                               | ROBERT ARTHUR   | 50N 3542  | 2 Baickwall Liv. 1  | ASADEN  | A. MD. ZIZZ   |   |       |       |       |                           |            |  |  |  |
| Baltimore,     |   |                               | 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ R                                       | emoval from State   | osition (Name of matory or other place)   | Date  | 20 . Location - City or Town, State                                     |   |       |       |       |                           |            |  |  |  |
| altin          | permit. Page<br>Department<br>Importent: If<br>sny Injury o   |                               | 4 ☐ Donation 5 ☐ Other (Specify)  21. Signature ☐ Turning Service License                       | DAYVIEW 2   | 2. Name and Address of Facility   | ces [   | STETIMURE, MIS.   |   |       |       |       |                           |            |  |  |  |
| ä              | Depa<br>Impo  |                               | MINOS   |   | Daugherty Family Funeral<br>2601 Mountain Roa   | d - Pasadena N  | AD 21122  |   |       |       |       |                           |            |  |  |  |
|                |   |                               | Immediate Cause (Final  | cations that caused the death. Do not en<br>e cause on each line.   |   |   | Onset and Death   |   |       |       |       |                           |            |  |  |  |
|                | Physician<br>/Medical<br>Examiner   |                               | disease or condition resulting in death)  | Due to (or as a consequence of):  | TRUCTIVE PUL  | MONAKY  | DISEASE 10 YEARS  |   |       |       |       |                           |            |  |  |  |
|                |   | er                            | Sequentially list conditions, if any, leading to immediate                                      | Due to (or as a consequence of):  |   |   |   |   |       |       |       |                           |            |  |  |  |
|                | ocuted<br>nd<br>transit   | Examiner                      | cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |   |   |   |   |   |       |       |       |                           |            |  |  |  |
| 8760,          | ficate be executed<br>physicien and<br>s the burial-transit   |                               | resulting in death) Last  | Due to (or as a consequence of):  |   |   |   |   |       |       |       |                           |            |  |  |  |
| 9              | rtificate<br>ng phys  | Medical                       | IF FEMALE:  |   |   |   |   |   |       |       |       |                           |            |  |  |  |
| Вох            | that the death certif<br>ed by the attending<br>detached for use a  | ian/                          | 23b. Was decedent pregnant in the past 12 months?   |   | □Ectopic pregnancy □ Other (specify)  |   | 23d. Date of delivery  Month Day Year                                   |   |       |       |       |                           |            |  |  |  |
| P.O.           | at the d<br>by the<br>tached  | by Physician/Me               | b   | hysic   | hysic   | hysic   | hysic   | hysi  | hysic | hysic | hysic | 1  Yes 2 No<br>9  Unknown | 9□ Unknown |  |  |  |
|                | es<br>Be  |                               |   | Part II. Other significant conditions con   | tributing to death but not resulting in the the HEART FAILU                           |   | 23e. Did tob  | pacco use contribute to the cause of death? |       |       |       |                           |            |  |  |  |
| COL            | aw requir<br>s been si<br>s should I  | ojetec                        |   | 24a. Was a  |   |   |   |   |       |       |       |                           |            |  |  |  |
| Vital Records, | The tay<br>cate has<br>page 2   | Completed                     |   |   |   | autops<br>perform                                       | prior to completion of cause of death?  1 Yes 2 No                      |   |       |       |       |                           |            |  |  |  |
| Vita           | sician: Th<br>certificate<br>irector, pag   | Be                            | 25. Was case referred to medical examiner?  1 \( \text{Yes} \) Yes                              | ospital: 1 Inpatient 2 ☐ ER/Outpatie  |   | ath (Check only on                                      |   |   |       |       |       |                           |            |  |  |  |
| n of           | ding Physician:<br>h.<br>After this certific<br>funeral director.   | on: To                        | 27. Manner of Death   | 28a. Date of Injury (Month, Day Year) Injury  |   | T   | ance 6  |   |       |       |       |                           |            |  |  |  |
| Division of    | Attending Physician: r deeth. sctor: After this certifica   | lication                      | 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be   | 28e. Płace of Injury - At home, farm, st  | M 1 Yes 2 No  | 28f. Location (Street and Number or Rural Route Number. |   |   |       |       |       |                           |            |  |  |  |
| <u>S</u>       | tal or A  | Certification:                | 4 Homicide determined   | n, State)   |   |   |   |   |       |       |       |                           |            |  |  |  |
|                | To the Hospital or Attent within 24 hours after deeth To the Funeral Director: completely filled in by the                                    | edical                        | 29a. Certifier (Crieck or ity one)  | sician: To the best of my knowledge, dea<br>left: On the basis of examination and/or in<br>and manner stated. | th occurred at the time, date and place overstigation, in my opinion, death occurred. | e, and due to the ca<br>urred at the time, da           | ause(s) and manner as stated.<br>ate and place, and due to the cause(s) |   |       |       |       |                           |            |  |  |  |
|                | To the within 2. To the complet   | Me                            | 29b. Signature and title of certifier   |   | 29c. License number   |   | 9d. Date signed (Month, Day, Year)                                      |   |       |       |       |                           |            |  |  |  |
| 2              |   |                               |   |   |   | ECEMBER 21 2005   |   |   |       |       |       |                           |            |  |  |  |
| 0              | 7   |                               | SAHIL SOOD .  | mpleted cause of death (Item 23a) (Type   |   | MORE,   | MD 21225  |   |       |       |       |                           |            |  |  |  |
|                | Sta<br>Registi  |                               | 31. Date filed (Month, Day, Year)<br>DEC 2 7 200  | 3601 S. HANOVE<br>32 Aegistrar's Signature  | series  |   |   |   |       |       |       |                           |            |  |  |  |

|                |   | •                 | For<br>State<br>Registrar  | State of Marylan  |   | ent of Health and<br>ate of Death  | Mental Hygien  | 000                                 | 41644   |   |  |                       |
|----------------|---|-------------------|--|---|---|--|--|-------------------------------------|---|---|--|-----------------------|
|                | Physicia<br>/Medic  |                   | 1. Decedent's Name (First, Middle, Last  | ADAMS   |   |  | 2. Date of Death<br>Month D                            | 16 Ž                                | 3. Time of Death $7.15 \text{ PM}$  |   |  |                       |
|                | Examin<br>Funeral   | 15                | 4a. Facility Name (If not institution, give  | SY CT.  | PRI   | NY, Town, or Location of Dec<br>Ser 1 Year If Under 24 Hi<br>s Days Hours Mi | S. 8. Date of Birth<br>(Month, Day, Yea                | c. County of Dea                    | th  ERT  thplace (State or Foreign  |   |  |                       |
| 400            | Director  | J.                | Usuel Residence of Decedent  10a. State  10b. County   | 10c. Cit  | ty, Town or Location  | 25552  | )  | 2 1/16                              | 10d. Inside City Limits   |   |  |                       |
|                | with the Mi<br>3a or 28e-f  | il Director       | 10e. Street and Number   | EX CT   | INCE F  | KEDERIC<br>Zip Code<br>20178   | 10g. C   | itizen of What Co                   |   |   |  |                       |
| 980            | in 72 hours after death with the Maryland<br>"naturel", or Items 23a or 28e-f show<br>refeal Exant et must be notified at                             | by Funeral        | 11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  | 12. Was Decedent Ever in U<br>Armed Forces?<br>1 Yes 2 No<br>If Yes, Give<br>Year or Dates: | If Yes, s   | cedent of Hispanic Origin?<br>pecify Cuban, Mexican, Pue                     | (Specify Yes or No-<br>orto Rican, etc.)               | 14. Race - Ame<br>Black, Whit       |   |   |  |                       |
| 21215-0036     |   | Completed         | 15. Decedent's Ed<br>(Specify only highest grad<br>Elementary/Secondary (0·12)   | completed)  College (1-4or 5+)  | 16a. Decedent's U<br>Give kind of<br>life. DO NOT               | work done during most of w   | orking 16b.  | Kind of Business                    | Industry  11 ON   |   |  |                       |
| Maryland       | should be filed within and Mental Hygiene. Is marked other then aumatic event, I'm Ma   | To Be C           | 17. Father's Name (First, Middle, Last) ANDREW WI  | LSON BUY  | 2DETTI  | E REV  | ame (First, Middle, Maide                              | TE                                  | 7.0.4   |   |  |                       |
| Baltimore, Mar | of Health if itam 27 or other tr  |                   | 19a. Informant's Name/Relationship (7)  DAMES B. ADAI  20a. Method of Disposition  1 Burial 2 Cremation 3 4 Woonation 5 Other (Specify                   | US / SPOUSE 20b. I  | 19b. Mailing Address Place of Disposition (Nemetery, crematory) | Name of other place)   | PRINCE FRE   | DERICK<br>Location - City or        | MD 2008   |   |  |                       |
| Balti          | permit. Pag<br>Department<br>Importent: i<br>eny injury o   |                   | 21. Signature of Funeral Service Licens  | 111/2   |   | and Address of Facility  |  | HEY M. HA                           | 20042, M231046  |   |  |                       |
| and the same   | Physician<br>/Medical<br>Examiner   |                   | 23a. Part1. Enter the disease, or comp<br>shock, or heart failure. List only of<br>Immediate Cause (Final<br>disease or condition<br>resulting in death) |   | cancer  | ode of dying, such as card   | ac or respiratory arrest,                              |                                     | Approximate Interval Between Onset and Death  Years                       |   |  |                       |
| 8760,          | e be executed<br>sicien and<br>e burial-transit   | cal Examiner      | Sequentially list conditions, 1 style-sons to modula cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last     | C.  Due to (or as a consected)  Due to (or as a consected)                                  |   |  |  |                                     |   |   |  |                       |
| P.O. Box 68    | law requires that the death centificate be executed as been signed by the attending physicien and s should be detached for use as the burial-transit. | Physician/Medical | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 MNo 9 □ Unknown   | 23c. If yes, outcome of pregn<br>1 Live birth 2 Feta<br>4 Pregnant at time of o             | al death 3 □Ectopic   | c pregnancy<br>(specify)   |  | 23d. Date of de<br>Month            | olivery<br>Day Year   |   |  |                       |
|                | The<br>ate h<br>page  | þ                 | þ  | þ   | Ď   | Part II. Other significant conditions or                                     | ontributing to death but not res                       | sulting in the underlyin            | g cause given in Part I.  | 23e. Did tobacco  |  | o the cause of death? |
| Vital Records, |   | Completed         |  |   |   |  | 24a. Was an autopsy performed?                         | prior to death?                     | utopsy findings available completion of cause of s 2 \( \subsection \) No |   |  |                       |
| Vita           | Physicien: The this certificate rat director, pag   | Be                | 25. Was case referred to medical examiner?   | Hospital:   | 3cB/0-45-4  | Othora   | eath (Check only one)                                  | 0.500                               |   |   |  |                       |
| ō              | d is  | ation; To         |  |   |   | 1 ☐ Yes 2 1 No  27. Manner of Death  1 1 Note                                | 28a. Date of Injury<br>(Month, Day Year)               | 28b. Time of Injury                 | 28c. Injury at Work?  | ng Home 5 ▼Residence 6 □ Other (Specify)  28d. Describe how injury occurred |  | ecify)                |
| Division       | 2 th 12 c   | Certification;    | 3 Suicide 6 Could not be<br>4 Homicide determined  | 28e. Place of Injury - At h<br>building, etc. (Speci  | nome, farm, street, fac<br>ify)                                 | tory, office   | 28f. Location (Street<br>City or Town, Sta             |                                     | lural Route Number,   |   |  |                       |
|                | To the Hospital of within 24 hours at To the Funeral Discompletely filled it  | edical            | 29a. Certifier 1 Certifying Ph<br>(Check only 2 Medical Examone)   | ysician: To the best of my kn<br>liner: On the basis of examin-<br>and manner stated.       | owledge, death occurr<br>ation and/or investigat                | ed at the time, date and plation, in my opinion, death oc                    | ce, and due to the cause<br>curred at the time, date a | s) and manner a<br>nd place, and du | s stated.<br>e to the cause(s)  |   |  |                       |
|                | To the within To the compl  | ₩<br>We           | 29b. Signature and title of certifier  | 2.1   |   | 29c. License number  |  | Date signed (Mon                    |   |   |  |                       |
|                | 1   |                   | · madely   | ME ME   |   | D005906  | 1 Dec  | ember                               | 2005  |   |  |                       |
| 2              | · ·   |                   | 30. Name and address of person who o   | completed cause of death (Ite   | Road  Road  | D005906<br>Svite 212   | Prince A   | ZOL                                 | 78  |   |  |                       |
|                | Sta<br>Regist   | ate<br>rar        | 31. Date filed (Month, Day, Year) DEC 2 7 200  | 5. Registrar's Sign   | ature   | 7  |  |                                     |   |   |  |                       |

|                            |  |                  | 1 _ State  | State of Marylan   |                                    | rtment of F  |  |   | 200                           | ELICIE  |
|----------------------------|--|------------------|--|--|------------------------------------|--|--|---|-------------------------------|---|
|                            | *  |                  | Registrar  1. Decedent's Name (First, Middle, Last)  |  | Certi                              | ilicate of t   | Deain  | Reg<br>2. Date of Death                   |                               | 3. Time of Death  |
|                            | Physici<br>/Medio  |                  | RICHARD  | P. AL  | EN                                 |  |  | DECEMBER                                  | 2 23 , 2                      | 1005 954AM  |
|                            | Examir   |                  | 4a. Facility Name (If not institution, give si   | 1 4 8 100 11   |                                    | 4b. City, Town, or   | Location of Death  |   | 4c. County of                 | A   |
|                            | Funeral  |                  | 5. Social Security Number 6. Sex   | 7. Age (In yrs. I  |                                    | If Under 1 Year  | If Under 24 Hrs.   | 8. Date of Birth<br>(Month, Day, Y        |                               | Birthplace (State or Foreign Country)                           |
|                            | Director   |                  | 217-24-2290  | <sup>M 2□ F</sup> 76   | Yrs.                               | Months Days  | Hours Min.   | 8-9-1929                                  | ear)                          | MD Country)   |
|                            | /land  |                  | Usual Residence of Decedent  10a. State 10b. County  | 10c. City  | , Town or Loca                     | ation  |  |   |                               | 10d. Inside City Limits   |
|                            | the Marylar<br>288-f show  | ctor             | MD Anne Aru  | ndel G1  | en Burn                            | nie  |  |   |                               | 1 ☐ Yes 2 No  |
| - 6                        | with the   | Funeral Director | 10e. Street and Number   |  |                                    | 10f. Zip Code  |  |   | . Cifizen of W                | hat Country?  |
| 4                          | leath w  | eral             | 512 Marion Road  | 2. Was Decedent Ever in U.   | S. 13. Wa                          | 2106   |  |   | U.S.A.                        | - American Indian.  |
| () o                       | after dea<br>or Itams  | Fun              | 1 ☐ Never Married 2K Married   | Armed Forces?  1 X Yes 2 □ No If Yes, Give                                   |                                    | Yes, specify Cuba<br>□ Yes 2X No                             | lispanic Origin? (Spe<br>an, Mexican, Puerto F<br>Specify: | Rican, etc.)                              | Black                         | k, White, etc.<br>White   |
| 1/2 / 2-0036               | 72 hours after death with the Maryland<br>naturel', or Itams 23a or 28a-f show<br>Leaf Examitter must be mortified at  | ed by            | 3 Widowed 4 Divorced   | Year or Dates:   |                                    |  |  | 1.00                                      |                               |   |
| 五5.                        | c 1.3  | Completed        | 15. Decedent's Educ<br>(Specify only highest grade<br>Elementary/Secondary (0-12)                      | completed) College (1-4or 5+)  | (Give kii<br>life. DC              | nt's Usual Occup<br>ind of work done of<br>O NOT use retired | ation<br>during most of working<br>i)                      | 9   | b. Kind of Bus                | siness/Industry   |
| 3 5                        | fited withi<br>Hygiene.<br>other ther  | Com              | 9  | College (1-401 3+)   | Machin                             | nist   |  |   | Indus                         |   |
|                            | uld be filed<br>flental Hyg<br>rked othe<br>tic event,   | Be               | 17. Father's Name (First, Middle, Last)  Joseph Allen  |  |                                    |  | 18. Mother's Name  | (First, Middle, Ma.<br>wn) Holt           |                               | )   |
| S S                        | s 1 and 2 should be filed within the Hall and Mantal Hygiene. I Health and Mental Hygiene. Item 27 is marked other than other traumatic event, the Mantal Hall and Mantal Hall | 스                | 19a. Informant's Name/Relationship (Typ  | ne, Print)   | 19b. Mailing                       | Address (Street  | and Number or Rural  |   |                               | State, Zip Code)  |
| ZŽ                         | and 2<br>ealth a<br>n 27 is  |                  | Mr. Richard Allen  |  |                                    |  | oad; Glen  | Burnie,                                   | Maryla                        | nd 21061  |
| 771 8                      | Pages 1<br>nent of He<br>int: If iten  |                  | 20a. Method of Disposition 13℃Burial 2 ☐ Cremation 3 ☐ Re  | anioval noin State   |                                    | tion (Name of<br>atory or other plac                         | l l  |   |                               | City or Town, State   |
| 7                          |  |                  | 4 ☐ Donation 5 ☐ Other (Specify)  21. Signat selot/Fin all S. Inice License                            |  |                                    |  | Cem. 12-2  |   |                               |   |
| A Ba                       | permit<br>Depart<br>Import<br>any in   |                  | ) X Ve   |  |                                    |  | Ave SW; G  |   |                               |   |
|                            |  |                  | 3a. Par 1. Enter the disease, or complice shock, or heart failure. List only one                       | ations that caused the death   |                                    | the mode of dyin   | g, such as cardiac or                                      | respiratory arrest                        |                               | Approximate<br>Interval Between                                 |
|                            | Physician  |                  | Inmediate Cause (Final disease or condition resulting in death)  |  | Sept                               | ie 14  | lock   |   |                               | Onset and Death   |
|                            | /Medical<br>Examiner   |                  |  | Due to (or as a consequ  | uence/of): _                       |  | 6.1  |   |                               |   |
|                            | 7 × 2  | ner              | Sequentially list conditions, b. a year inglocations clause. Enter Underlying Cause (Disease or injury | Due to (or as a consequ  | ience of):                         | 1  | ractive  |   |                               |   |
| fe                         | executed<br>in and<br>ial-transif  | Examiner         | Cause (Disease or injury that initiated events resulting in death) Last                                | Due to (or as a conseq   | Con atti                           | tim  | Maracan  |   |                               |   |
| 8760,                      | ate be executed hysicien and the burial-transif  | calE             |  | Due to (or as a conseq   | 17.1                               |  | 50   |   |                               |   |
| 687                        | tificate<br>ng phy<br>as the   | ed               | 0.   |  |                                    |  |  |   |                               |   |
| Box 6                      | that the death certifi<br>ed by the attending<br>detached for use as   | lan/N            | IF FEMALE: 23b. Was decedent pregnant in the past 12 months?   | lc. ff yes, outcome of pregna<br>1□Live birth 2□Fetal                        | death 3 □E                         | ctopic pregnancy   |  |   | 23d. Date<br>Mont             | of delivery<br>th Day Year                                      |
| P.O.                       | the dear<br>the a  | yslc             | 1 ☐ Yes 2 ☐ No<br>9 ☐ Unknown  | 4□Pregnant at time of de<br>9□Unknown  | eath 5□C                           | Other (specify)  |  |   | IVIOITE                       | n Day real  |
| مَ مَ                      | Attending Physician: The law requires that the death certifical death.  Getor: After this certificate has been signed by the attending phy the funeral director, page 2 should be detached for use as th   | by Physician/M   | Part II. Other significant conditions cont   | inbuting to death but not resu   | iffing in the und                  | lerlying cause give  | en in Part I.  | 23e. Did tobac                            | co use contrit                | bute to the cause of death?                                     |
| Division of Vital Records, | w requires that<br>been signed b<br>should be deta   |                  |  |  |                                    |  |  | 1 🗆 Yes                                   | 2 <b>(4)</b> 0 3              | Probably 4 Unknown  |
| ec.                        | e law i<br>has bo  | Completed        |  |  |                                    |  |  | 24a. Was an autopsy                       | 24b. W                        | ere autopsy findings available<br>for to completion of cause of |
| tal F                      | ding Physician: The I<br>h.<br>After this certificate ha<br>funeral director, page   |                  | 25. Was case referred to medical   |  |                                    |  | 00 DI (D )   | performed                                 | No 1                          | eath?<br>☐ Yes 2 ☐ No   |
| Ž                          | Physicia<br>this cert<br>al direct   | To Be            | eyaminer?  | ospital: 1 Depatient 2 1   | ER/Outpatient                      | 3□ DOA Othe  | 26. Place of Death<br>er:<br>4 ☐ Nursing Hom               | e 5 🗆 Residenc                            | e 6 □Other                    | · (Specify)   |
| 0                          | ding Ph<br>.r<br>After th<br>funeral   | on:              | 27. Manner of Death 1 ☐Naturaf 5 ☐ Pending   | 28a. Date of Injury<br>(Month, Day Year)                                     | 28b. Time of<br>Injury             | 28c. Injury<br>Work  | / at 2   | 8d. Describe how                          |                               |   |
| isio                       | otor: A  | licati           | 2 Accident investigation 3 Suicide 6 Could not be  | 28e. Place of Injury - At ho   | me farm stree                      |  | Yes 2 □No  | 8f. Location (Stree                       | and Number                    | r or Rural Route Number.  |
| D.                         | el or A<br>s after<br>al Dire  | Certification:   | 4 Homicide determined  | building, etc. (Specify  | )                                  | n, radiory, ornoc  |  | City or Town, S                           | tate)                         | or rata riodio ivambor,   |
|                            | To the Hospitel or Attendi<br>within 24 hours after death.<br>To the Funerel Director: A<br>completely filled in by the fu   | edical (         | 29a. Certifier 1 Certifying Physic (Check only one) 2 Medical Examina                                  | ician: To the best of my knower: On the basis of examinat and manner stated. | wledge, death o<br>ion and/or inve | occurred at the tim<br>stigation, in my of                   | ne, date and place, a<br>pinion, death occurre             | nd due to the caus<br>d at the time, date | e(s) and man<br>and place, ar | ner as stated.<br>nd due to the cause(s)                        |
| _                          | To the within To the comple  | Me               | 29b. Signature and title of certifier  | and market stated.   |                                    | 29c. License   | number -   | 29d.                                      | Date signed                   | (Month, Day, Year)  |
|                            |  |                  | 1 Obacre   | Real   |                                    | DOC  | 14147  | De  | 3cembe                        | er 23 2005  |
|                            | $\sigma_{i}$   |                  | 30. Name and address of person who con   | -  | -                                  | rint)  | 5 1/ 3   |   | D                             | er 23 1005  |
|                            | Sta  | te               | 31. Date filed (Month, Day, Year)  | 32. Registrar's Signat   | Ur9 /27/27/                        | Dr.  | ruite 30   | 5 Okn                                     | Durn                          | ne MD 2106  |
|                            | Registr  |                  | DEC 2 7 2005   | E H  | Back !                             | ,  |  |   |                               |   |

|                   |   |                     | For State  | State of Maryland / Depa  |  | Mental Hygie                             | <b>2e</b> 005                        | 41646   |
|-------------------|---|---------------------|--|---|--|--|--------------------------------------|---|
|                   |   |                     | 1. Decedent's Name (First, Middle, Las   |   | tilicate of Beath  | 2. Date of Death                         | J. No.                               | 3. Time of Death                              |
|                   | Physici   | an                  |  |   |  | Month                                    | Day Year                             | 14  |
|                   | _/Medic   |                     | George R. Albrigh  4a. Fecility Name (If not institution, give                     |   | 4b. City, Town, or Location of De                                      | December                                 | 4, 2005<br>4c. County of Deeth       | 6:25 AM <sup>™</sup>                          |
|                   | Examir  | ier                 | 2 Brecon Place   | s street and trainbory  | Cockeysville   |  | Baltimo                              |   |
|                   | Euparal   |                     | 5. Social Security Number 6. S   | ex 7. Age (In yrs. last birthday)                                   | If Under 1 Year If Under 24 H  |  |                                      | place (State or Foreign<br>ntry)              |
|                   | Funeral Director  |                     | 215-34-0488  | ™ 2□F 68 Yrs.   | Months Days Hours Mi   | July 20.                                 | 1937 Mary                            | ntry)<br>11and                                |
|                   | Ö   |                     | Usual Residence of Decedent  |   |  |  |                                      |   |
|                   | trylar<br>thow  |                     | 10a. State 10b. County   | 10c. City, Town or Lo   |  |  |                                      | 10d. Inside City Limits                       |
|                   | Ba-f.   | cto                 | MD Baltime   | ore Cockey  | sville   |  |                                      | 1 ☐ Yes 2√ No                                 |
|                   | ith th  | Dire                | 10e. Street and Number   |   | 10f. Zip Code  |  | g. Citizen of What Cou               | ntry?   |
|                   | ath w   | by Funeral Director | 2 Brecon Place   |   | 21030  |  | USA                                  |   |
|                   | er de   | nue                 | 11. Marital Status   | 12. Was Decedent Ever in U.S. Armed Forces?                         | Was Decedent of Hispanic Origin?<br>If Yes, specify Cuban, Mexican, Pu | (Specify Yes or No-<br>erto Rican, etc.) | 14. Race - Ameri<br>Black, White     |   |
| 36                | s afte  | yΕ                  | 1 ☐ Never Married 2 🔯 Married<br>3 ☐ Widowed 4 ☐ Divorced                          | 1 Styes 2 □ No If Yes, Give Year or Dates: 160-65                   | 1 ☐ Yes 2 ☑ No Specify:  |  | Specify: W                           | nite  |
| 21215-0036        | 72 hours after death with the Maryland<br>naturel', or Items 23s or 28s-f show<br>dical Examiner must be notified at  |                     | 15. Decedent's Ed  |   | dent's Usual Occupation  | 16                                       | 6b. Kind of Business/Ir              | ndustry unk                                   |
| 15                | in 72   | piet                | (Specify only highest gra  | de completed) (Give   | kind of work done during most of w<br>DO NOT use retired)              | vorking                                  |                                      | unk   |
| 212               | within iene.  | Completed           | Elementary/Secondary (0-12)  | College (1-4or 5+)  | builder  |  |                                      |   |
| b                 | I Hygie<br>other  | BeC                 | 17. Father's Name (First, Middle, Last)  |   |  | ame (First, Middle, Ma                   | uiden Sumame)                        |   |
| <u>a</u>          | Ald be denta  | To B                | George Conrad A  | lbright   | Mary   | Eileen Bye                               | ers                                  |   |
| Maryland          | 2 should be and Mental Is marked o  | -                   | 19a. Informant's Name/Relationship (   | Type, Print) 19b. Mailie  | ng Address (Street and Number or                                       | Rural Route Number, (                    | City or Town, State, Zi              | p Code)                                       |
|                   | s 1 and 2 should be filed within 72 hours after death with the Marylan if Health and Mental Hygiene. Item 27 is marked other than "naturel", or Items 23a or 28a-f show other traumatic event, the Modical Examiner must be notified at |                     | Doris J. Albrigh   | t/spouse 2 B  | recon Place Cock   | eysville,                                | MD 21030                             |   |
| Baltimore,        | of Health<br>of Health<br>item 27   |                     | 20a. Method of Disposition   | 20b. Place of Dispo<br>cemetery, crei                               | osition (Name of matory or other place)                                | Date 20                                  | c. Location - City or T              | own, State                                    |
| Ĕ                 | Page<br>nent o<br>ant: If<br>ury or   |                     | 1 ☐ Burial 2 ☐ Cremation 3 ☐  '4 ☐ Donation 5 ☐ Other (Specify                     |   |  |  |                                      |   |
| att               | permit. Pages Department of I Importent: If ite any injury or of  |                     | 21. Signature of Funeral Service Licer<br>RODA Ld S                                | Wade, Director Si   | Name and Address of Facility<br>tate Anatomy Boa                       | rd 655 W. I                              | Raltimore :                          | Street  |
| 0                 | Dep<br>Imp  |                     | surenfl !  |   | altimore, MD 21.   | 201                                      | Jaie I more                          |   |
|                   |   |                     | 23a. Part 1. Enter the dis Ase, ir com shock, or heart failure. List only          | plications that caused the deeth. Do not entone cause on each line. |  |  | it,                                  | Approximate<br>Interval Between               |
|                   | Physician   |                     | Immediate Cause (Final disease or condition  | Metastatic  | . Non-small (  | 'ell Lung (                              | ancer                                | Onset and Death                               |
| Now               | /Medical  |                     | resulting in death)  | Due to (or as a consequence of):                                    |  |  |                                      | 12 1101111                                    |
| - Q               | Examiner  |                     | Sequentially list conditions   | b   |  | V  |                                      |   |
|                   | D =   | Examiner            | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying | Due to (or as a consequence of):                                    |  |  |                                      |   |
|                   | be executed<br>sician and<br>burial-transit   | am                  | Cause (Disease or injury that initiated events resulting in death) Last            | c   |  |  |                                      |   |
| 760,              | e be execut<br>rsician and<br>e burial-tran   |                     | resulting in death) cast   | Due to (or as a consequence of):                                    |  |  | - 1                                  |   |
|                   | hysic<br>the b  | dical               |  | d   |  |  |                                      |   |
| x 68              | eath certificate t<br>attending physic<br>I for use as the b  | hysician/Medi       | IF FEMALE:   | 23c. If yes, outcome of pregnancy                                   |  |  |                                      |   |
| Вох               | death o   | lan/                | 23b. Was decedent pregnant in the past 12 months?                                  | 1 Live birth 2 Fetal death 3  | Ectopic pregnancy  |  | 23d. Date of delive Month            | ery<br>Day Year                               |
| 0                 | 0 0   | sic                 | 1 ☐ Yes 2 ☐ No<br>9 ☐ Unknown  | 4☐Pregnant at time of death 5☐<br>9☐ Unknown                        | Other (specify)  |  |                                      |   |
| α.                | requires that the de<br>een signed by the a<br>nould be detached t  | Q.                  |  | ontributing to death but not resulting in the u                     | nderlying cause given in Part I.                                       | 23e. Did toba                            | cco use contribute to                | the cause of death?                           |
| ds,               | signe<br>d be   | 1 by                | •  |   | , ,  | 1 🗆 Yes                                  | 2 □ No 3 Pro                         | bably 4 Unknown                               |
| 0.0               | w requir<br>been si<br>should   | ompieted            |  |   |  | 245 1465                                 | 245 Wass and                         |   |
| 3ec               | has<br>has  | mpi                 |  |   |  | 24a. Was an autopsy                      | prior to co                          | opsy findings available ompletion of cause of |
| la<br>F           | icien: The l<br>certificate ha<br>rector, page  | O                   |  |   |  | 1 Yes 2                                  | □ No 1 □ Yes                         | 2 No  |
| of Vital Records, | icien:<br>certific<br>rector,   | Be                  | 25. Was case referred to medical examiner?   | Hospital:   | Other  | eath (Check only one)                    |                                      |   |
| of                | Phys<br>r this<br>ral dir   | J.                  | 1 Yes 2 No 27. Manner of Death   | 1 ☐ Inpatient 2 ☐ ER/Outpatier  28a. Date of Injury 28b. Time o     | 1 3 DOA 4 Nursing  | Home 5 Pesiden<br>28d. Describe how      | ce 6 Other (Speci<br>injury occurred | fy)   |
| DO                | ding I<br>h.<br>After<br>funer  | tion                | 1 Accident 5 Pending investigation   | (Month, Day Year) Injury  | f 28c. Injury at<br>Work?<br>M 1 ☐ Yes 2 ☐ No                          | 0  |                                      |   |
| Division          | of or Attending Physicien:<br>after death.<br>I Director: After this certification by the funeral director.   | Certification;      | 3 ☐ Suicide 6 ☐ Could not b  | e 28e. Place of Injury - At home, farm, str                         | reet, factory, office  |  | et and Number or Rui                 | al Route Number,                              |
| Š                 | after<br>Dire<br>Jin b  | erti                | 4 Homicide   | building, etc. (Specify)  | •  | City or Town,                            | State)                               |   |
|                   | To the Hospitel or Attu<br>within 24 hours after de<br>To the Funerel Directo<br>completely filled in by th   |                     | 29a. Certifier Certifying Ph   | ysician: To the best of my knowledge, deat                          | h occurred at the time, date and pla                                   | ice, and due to the cau                  | ise(s) and manner as                 | stated.                                       |
|                   | e Ho<br>24 h<br>e Fui<br>letely   | Medical             | (Check only 2 Medical Exer   | niner: On the basis of examination and/or in<br>and manner stated.  | vestigation, in my opinion, death of                                   | curred at the time, dat                  | e and place, and due                 | to the cause(s)                               |
|                   | To the<br>within 2<br>To the<br>comple  | Σ                   | 29b. Signature and title of certifier  | 1   | 29c. License number  | 290                                      | d. Date signed (Month)               |   |
|                   |   |                     | Kobert 1   | MEXAM UNCOlogue   | DØ Ø 56°   | 119                                      | 12/19/0                              | 5   |
|                   |   |                     | 30 Name and address of person who  | completed cause of death (Item 23a) (Type,                          | Print)   |  |                                      |   |
|                   |   |                     | Kobert Do  | negan !   | salto ma   | ·  |                                      |   |
|                   |   | ate                 | 31. Date filed (Month, Day, Year)  | 32 Registrar's Signature  | and a  |  |                                      |   |
| 100               | Regist  |                     | DEC 2 7 76   | HD ANDERSON AND AND AND   |  |  |                                      |   |

|                                       |  | ·              | For<br>State<br>Registrar   |                                       |  | Marylar                |                                | artment<br>ertificate                         |                                 |                               | Mental Hy                               | Reg. No.              | 000                             | 41647  |
|---------------------------------------|--|----------------|---|---------------------------------------|--|------------------------|--------------------------------|---|---------------------------------|-------------------------------|---|-----------------------|---------------------------------|--|
|                                       | Physici<br>/Medic  |                | Decedent's Name   |                                       | Debr   |                        | rie Bo                         | stic  |                                 |                               | 2. Date of Do<br>Month<br>DECEMBE       | Day                   | Year<br>3, 200                  | 4.4  |
|                                       | Examin   | er             | 4a. Facility Name (#<br>Saint   | fnot institution, give<br>Joseph      |  |                        | nter                           | 4b. City, T                                   | own, or Loca                    | ation of Dea<br>Tow           |   | 4c.                   | County of Dea                   | uth<br>Ltimore                                     |
| 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 | Funeral<br>Director  |                | 5. Social Security No. 212-64-23  | 144                                   | ex 7<br>□M 2 <b>X</b> F  | Age (In yrs.           | last birthday<br>Yrs.          | ) If Under 1<br>Months                        |                                 | Jnder 24 Hrs<br>ours Min      |   | ay, Year)             | _ C                             | nthplace (State or Foreign<br>ountry)<br>aryland   |
|                                       | /land  |                | Usual Residence of<br>10a. State  | 10b. County                           |  | 10c. Ci                | ty, Town or L                  | ocation.                                      |                                 |                               |   |                       |                                 | 10d. Inside City Limits                            |
|                                       | a-feh  | ctor           | MD  | Washingt                              | on   | Sm                     | ithsbu                         | rg  |                                 |                               |   |                       |                                 | 1 ☐ Yes 2 XNo                                      |
|                                       | or 28  | Director       | 10e. Street and Nun   | nber                                  |  |                        |                                | 10f. Zip (                                    | Code                            |                               |   | 10g. Citi             | zen of What C                   | ountry?  |
|                                       | sath w   | eral           | 12016 Pic   | oneer Dri                             | VE<br>12. Was Decede   | nt Ever in II          | 10 12                          | 217   |                                 | in Origina (                  | Spacety Vac as N                        | U.S.                  | A.<br>14. Race - Am             | orizon Indian                                      |
| 936                                   | urs after d  | by Funeral     | 11. Marital Status  1 Never Marrie 3 Widowed  | ed 2 Married 4 Divorced               | Armed Force 1 Tes 2 If Yes, Give Year or Date:                       | s?<br>∑No              | .3.                            | If Yes, speci                                 |                                 | exican, Pue                   | Specify Yes or No<br>to Rican, etc.)    | -                     | Black, Whi                      | ite, etc.  |
| Maryland 21215-0036                   | 2 should be filed within 72 hours after death with the Maryland and Menth Hygiene. and Menther Hygiene is marked other than "natural", or Items 23s or 28s-1 ehow aumatic event, it is Medical Exact in an institute at its difficult at | Completed      | (Speci  | 15. Decedent's Edify only highest gra | lucation<br>de completed)<br>College (1-4c                           | or 5+)                 | (Giv                           | edent's Usual<br>e kind of work<br>DO NOT use | done during                     | g most of wo                  | prking                                  | 1                     | nd of Business                  |  |
| 2                                     | filed wi<br>Hygien<br>other th   |                | 12  | (Cina Middle 1 - an)                  |  |                        | Home                           | maker   | 10                              | 1 4 - 4 b ( b) -              |   |                       | Home                            |  |
| anc                                   | d be fi  | o Be           | 17. Father's Name ( John Stor   |                                       |  |                        |                                |   |                                 |                               | me <i>(First, Middle</i><br>ilkinsor    |                       | Sumame)                         |  |
| ary                                   | s 1 and 2 should be<br>if Health and Mental<br>Item 27 is marked other traumatic ev  | 2              | 19a. Informant's Na   |                                       | Гурө, Print)   |                        | 19b. Mai                       | ing Address                                   |                                 |                               | ural Route Numb                         |                       | r Town, State,                  | Zip Code)  |
|                                       | 5 5 5 E  |                | Gary Bost   | tic /spo                              | use  |                        |                                |   |                                 | cive,                         | Smithsbu                                | ırg,                  | Maryla                          | nd 21783   |
| Baltimore,                            | permit. Pages 1 an<br>Department of Heal<br>Important: If Item 2<br>eny injury or othar<br>once.   |                | 20a. Method of Disp   | oosition<br>Cremation 3               | Removal from Sta   | 20b. F                 | Place of Disp<br>cemetery, cre | osition (Name<br>ematory or oth               | e of<br>ner place)              |                               | Date                                    | 20c. Lo               | cation - City or                | Town, State  |
| Ē                                     | t. Pag<br>rtmen<br>rtant:<br>njury   | 1              | 4 Donation  | 5 Other (Specify                      | ')   |                        | 1                              | dge Me  |                                 |                               | 29, 05                                  | Dors                  | sey, Ma                         | ryland   |
| Ba                                    | permit. Departm Imports eny inju   |                | 21. Signature of Fu   |                                       | See  | — моот                 |                                | 22. Name and<br>Donald<br>313 Ta              | son Fu                          | ıneral                        | Home, I<br>Laurel,                      | A.<br>Mary            | land 20                         | 0707-4389  |
|                                       |  |                | 23a. Part1. Enter shock, or hear Immediate Cause (  | rt failure. List only                 | olications that caus<br>one cause on each                            | sed the deat<br>line.  | h. Do not er                   | nter the mode                                 | of dying, suc                   | ch as cardia                  | c or respiratory a                      | irrest,               |                                 | Approximate<br>Interval Between<br>Onset and Death |
|                                       | Physician<br>/Medical  |                | disease or condition<br>resulting in death)   | n and                                 |  | ARDIA                  |                                | FARCT:  | ION                             |                               |   |                       |                                 |  |
|                                       | Examiner   |                | Conventially list some  | aditions.                             |  |                        |                                | /POTEN  | 4SION                           |                               |   |                       |                                 |  |
|                                       | sit ad   | iner           | Sequentially list cor<br>if any, leading to im<br>cause. Enter Under<br>Cause (Disease or i | mediate                               |  | as a conseq            | uence of):                     |   |                                 |                               |   |                       |                                 | ,  |
| ,                                     | execute<br>n and<br>ial-tran   | Examiner       | that initiated events<br>resulting in death) L  |                                       | c. Due to (or a  | as a conseq            | juence of):                    |   |                                 |                               |   |                       |                                 |  |
| 28/60                                 | ificate be executed<br>physician and<br>as the burial-transit  | edicai         |   |                                       | d  |                        |                                |   |                                 |                               |   |                       |                                 |  |
| O. Box 6                              | The law requires that the death certific<br>te has been signed by the attending p<br>bage 2 should be detached for use as  | Physician/Me   | IF FEMALE: 23b. Was decedent in the past 12: 1  Yes 2  Unknown                              | months?                               | 23c. If yes, outcon<br>1 ☐ Live birth<br>4 ☐ Pregnant<br>9 ☐ Unknown | 2 Feta<br>at time of d | death 3                        | □Ectopic pre<br>□ Other (spe                  |                                 |                               |   | 2                     | 3d. Date of de<br>Month         | livery<br>Day Year                                 |
| ds, P                                 | quires that<br>n signed by<br>ald be deta  | þ              | Part II. Other signifi  | icant conditions o                    | ontributing to death   | but not res            | ulting in the                  | underlying ca                                 | use given in l                  | Part I.                       |   | tobacco u<br>Yes 2[   |                                 | o the cause of death?                              |
| Vital Records,                        | Physician: The law require<br>this certificate has been si<br>al director, page 2 should t   | Completed      |   |                                       |  |                        |                                |   |                                 |                               |   | psy<br>ormed?         | prior to death?                 | utopsy findings available completion of cause of   |
|                                       |  | BeC            | 25. Was case referr examiner?   | ed to medical                         |  |                        |                                |   | 26.                             | Place of De                   | 1 ☐ Yes<br>ath (Check only              | 2 <b>X</b> No<br>оле) | 1 Tes                           | s 2 <b>X</b> No                                    |
| o to                                  | Physic<br>this ce  | ၉              | 1 Yes 2   |                                       | Hospital: 1 Inpa   |                        | ER/Outpatie                    |   |                                 | ☐ Nursing                     | dome 5 ☐ Resi                           |                       |                                 | ecify)   |
| lon                                   | Attending F<br>death.<br>ctor: After<br>y the funer  | ation:         | 27. Manner of Death  1 Natural  2 □ Accident  | n<br>5 ☐ Pending<br>investigation     |  | ojury<br>Day Year)     | 28b. Time<br>Injury            | of 28   | c. Injury at<br>Work?<br>1  Yes | 2 🗆 No                        | 28d. Describe                           | how injury            | occurred                        |  |
| DIVISION                              |  | Certification: | 3 🗀 Suicide<br>4 🗀 Homicide   | 6 Could not be<br>determined          | 286. Place of  | Injury - At h          | ome, farm, s                   | reet, factory,                                | office                          |                               | 28f. Location (<br>City or To           |                       |                                 | ural Route Number,                                 |
|                                       | To the Hospital or within 24 hours afte To the Funaral Dir completely filled in  | Medical        | 29a. Certifier<br>(Check only<br>one)   | 1 Certifying Ph<br>2 Medical Exam     | ysician: To the be<br>niner: On the basis<br>and manner              | s ot examina           | wledge, dea<br>ition and/or i  | th occurred a<br>nvestigation, i              | t the time, da<br>n my opinion  | ate and place<br>n, death occ | e, and due to the<br>urred at the time, | cause(s)<br>date and  | and manner as<br>place, and due | s stated.<br>e to the cause(s)                     |
|                                       | To the within 2. To the complet  | 2              | 29b. Signature and  | title of certifier                    |  |                        |                                | 29c.  | License nurr                    | nber                          |   |                       | signed (Mont                    |  |
| ,                                     | 'n   | }              | 30. Name and addre  | 10                                    | completed assure   | f dooth /tt-           | n 22a\ /f                      |   | )4635(                          | 6                             |   | Dece                  | m bei                           | 23,2005  |
|                                       | .)   |                |   | TABASE                                |  |                        |                                |   | VOT HE                          | The task                      | ICTOBL NAM                              | mvi a                 | atim med                        | m m v  |
| · ·                                   | Sta<br>Registr   | te<br>ar       | 31. Date filed (Man   | EC 2 7 20                             | 32 Regis   | strar's Signa          | ature                          | MEN L   | RIVE                            |                               | ISON, MA                                | 1 1                   | HYL E.L                         | are 1/3 / 3  |

|              |  |                     | 1 - For State Registrar   | State of Maryland  | Department of Health Certificate of Death  |   | 2000 91090   |
|--------------|--|---------------------|---|--|--|---|--|
| )            | Physici<br>/Medi<br>Examir   | cal                 | 1. Decedent's Name (First, Middle, Last, R C H A R 4a. Facility Name (If not institution, give  | Street and number)   | BLICK  4b. City, Town, or Location   |   | Day Year 3. Time of Death 9:53 A M 4c. County of Death           |
|              | Funeral<br>Director  |                     | 2 3 0 3 PEN 5. Social Security Number 6. Sec. 2 1 8 - 60 - 260 8 15 Usual Residence of Decedent   |  |  | r 24 Hrs. 8. Date of Birth (Month, Day, Ye            | 9. Birthplace (State or Foreign Country) 9. A RYLAND             |
|              | ith the Maryland<br>or 28e-f show  | Director            | 10a. State 10b. County  MARVIAND  10e. Street and Number  | 10c. City, T   | own or Location  ALTI  10f. Zip Code   | MORE C  | 10d. Inside City Limits 1 ☑ Yes 2 ☐ No  Citizen of What Country? |
| 2-0036       | d 2 should be filed within 72 hours after death with the Maryland th and Mental Hyglene. It is marked other then "neturel", or Items 23a or 28e-1 show treumetic event. The Madical Exertire must be routile of an | by Funerai          | 11. Marital Status  1 X Never Married 2 Married  3 Widowed 4 Divorced   | 12. Was Decedent Ever in U.S.<br>Armed Forces?<br>1 Yes, Give<br>Year or Dates:                                  | 13. Was Decedent of Hispanic Or If Yes, specify Cuban, Mexica  |   | 14. Race - American Indian,<br>Black, White, etc.                |
| 1212         | filed within 72 ho<br>Hygiene.<br>other then "netur<br>ent, the Medical  | Completed           | 15. Decedent's Edu<br>(Specify onfy highest gradi<br>Elementary/Secondary (0-12)<br>2 ++G RAD E<br>17. Father's Name (First, Middle, Last)              | cation 1 completed) College (1-4or 5+)   | 6a. Decedent's Usual Occupation (Give kind of work done during mos life. DO NOT use retired)  TELLE  18 Moth | st of working  16b  16c  16c  16c  16c  16c  16c  16c | BANK   |
| Maryland     | 2 should be in and Mental is marked ore  | To Be               | TAMES  19a. Informant's Name/Relationship (Ty   | 00, Print)   | 21CK E. 9b. Mailing Address (Street and Numb   | LSIE<br>Per or Rural Route Number, Ci                 | BROWN  |
| saitimore, n | Pages 1 an<br>ment of Heal<br>ent: If item 2<br>ury or other   |                     | 20a. Method of Disposition  1 Disposition  2 Cremation 3 R  4 Donation 5 Other (Specify)  |  | e of Disposition (Name of etery, crematory or other place)   |   | ALTO, MD 21215  Location - City or Town, State  ALTI HORE, MD.   |
| Dal          | permit. Pa<br>Departmen<br>Importent<br>any injury<br>once.  |                     | 21. Signature of Euneral Service License  23a. Part1. Enter the disease, or complishock, or heart failure. List only or                                 | Cations that caused the death. D   | 22 Name and Address of, acili  | BROWN<br>ULTON AVE.                                   | TR. FUNERAL HOME, BALTO, MD, 2/2/17 Approximate Interval Between |
| <b>P</b>     | Physician<br>/Medical<br>Examiner  |                     | Immediate Cause (Final disease or condition resulting in death)   | Due to (or as a consequent   | ATIONS OF  | DIABE   | Onset and Death  |
| ,007         | ate be executed thysician and the burial-transit   | dical Examiner      | Sequentially list conditions, a.y, leading to in rediat cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | Due to (or as a consequent   |  |   |  |
| O. DOX of    | The law requires that the death certificate be executed ite has been signed by the attending physician and page 2 should be detached for use as the burial-transit   | Physician/Med       | #FFEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  | 3c. If yes, outcome of pregnancy<br>1 ☐ Live birth 2 ☐ Fetal de:<br>4 ☐ Pregnant at time of death<br>9 ☐ Unknown |  |   | 23d. Date of delivery<br>Month Day Year                          |
| corus, r     | requires that<br>een signed k<br>nould be det  | by                  | Part II. Other significant conditions con   | tributing to death but not resultin  | g in the underlying cause given in Part I  |   | co use contribute to the cause of death?                         |
| אוומווע      | iclen: The law<br>certificate has b<br>rector, page 2 s  | se Completed        | 25. Was case referred to medical  |  | 26. Place  | 24a. Was an autopsy performed 1 Yes 254               |  |
| SIOII OI A   | Phye<br>this<br>al dii   | Certification: To B | examiner?  1  | 28a. Date of Injury<br>(Month, Day Year) 28t   | Outpatient 3 DOA Other. 4 Nu 5. Time of lnjury at Work?  M 1 Yes 2   | rsing Home Residence 28d. Describe how in             | njury occurred   |
| 2            | To the Hospitel or Attending I within 24 hours after death. To the Funerel Director: After completely filled in by the funer   |                     | 4 ☐ Homicide determined  29a. Certifier ☐ Certifying Phys   | 28e. Place of Injury - At home, building, etc. (Specify)   | Ine death occurred at the time, data an  | City or Town, St                                      | /a\and manager and a   |
|              | To the H within 24 To the Fi   | Medical             | 29b. Signature and title of certifier   | and manner stated.  3 a. M. D.   | 29c. License number  | 29d. I<br>2 9 1 3 DE                                  | Date signed (Month, Day, Year)  CEMBER 22 2005                   |
|              | J<br>Sta   | ite                 | 30. Name and address of person who com MANISHA BAHL 31. Date filed (Month, Day, Year) DEC 2 7 2005  | mpleted cause of death (Item 23)<br>5601 LO(14)<br>32. Registrar's Signature                                     | RAVEN BOULEV   | MARITAN H<br>ARD, BALTI                               | HOSPITAL<br>MORE MD 21239  |
|              | Registr  | ar                  | BEU Z 7 2005  | 150 al 15 16   |  |   |  |

|  | ian   | 1. Decedent's Name (First, Middle, La   | Lena   | Bruns  | on   |  | 2. Date of D   |  | 3. Time of Death  |
|--|---|---|--|--|--|--|--|--|---|
| /Medi  | cal   | 4a. Facility Name (If not institution, gir  | ya street and number   |  | 4h City Tow  | vn, or Location of   | Destruct   | 4c. County of  | Doub / Els A  |
| xamii  | ner   | ta. I down wante in not insulation, gr  | T It soin  | 4.1  | 10.00y, 10.00  | district.  | )  | 12/  | <b>→</b> °  |
| neral  | 1   |   |  | e (In yrs. last birthda)   | y) If Under 1 Y  |  |  | lirth S  | 9. Birthplace (State or Foreig  |
| ector  |   | 216-80-8776   | 1□M 2XTF   | 76 Yrs.  | Months Da  | ays Hours  |  | 5/1929   | N. CAROLINA   |
| >  |   | Usual Residence of Decedent  10a, State 10b, County   |  | 10c. City, Town or I   | Location   |  |  |  | 10d. Inside City Limit  |
| "neture", or itema 23a or 28a-1 show<br>blical Examinar musi ba notified at  | 5   | MD N/A  |  |  | TIMORE   | $CT\Psi V$   |  |  | 1 Ves 2 N   |
| 188  | Director  | 10e. Street and Number  |  | 5112   | 10f. Zip Coo   |  |  | 10g. Citizen of Wh   | - 11  |
| 38 04  |   | 3008 MANHATTA   | N AVENUE   |  | 21   | 1215   |  | USA  |   |
| E III  | Funerai   | 11. Marital Status  | 12. Was Decedent 8<br>Armed Forces?  | Ever in U.S. 13  |  |  | n? (Specify Yes or N<br>Puerto Rican, etc.)  |  | American Indian,  |
| or all   |   | 1 ☐ Never Married 2 ☐ Married   | 1 ☐ Yes 2 💢 N  | lo   | 1 Yes 3  |  | rueno rican, etc.)   | Specify:   | White, etc.   |
| ure.   | d by  | 3 XWidowed 4 □ Divorced   | Year or Dates:   |  |  |  |  |  | BLACK   |
| allo   | Completed   | 15. Decedent's E<br>(Specify only highest gr  |  | (Giv   | cedent's Usual Oc<br>ve kind of work do<br>. DO NOT use re   | one during most o  | of working   | 16b. Kind of Busi  | ness/Industry   |
| 필  | E G   | Elementary/Secondary (0-12)<br>8TH  | Colfege (1-4or 5   | +)   | DOMESTI  |  |  | DOMES  | rtc   |
| event,   | BeC   | 17. Father's Name (First, Middle, Las   | t)   |  |  | 18. Mother's   | s Name (First, Midd  | e, Maiden Sumame)  |   |
|  | To B  | NORMAN TAYLO  | R  |  |  | LE   | NA PHILI   | TPS  |   |
| 7 is marke<br>treumatic  |   | 19a. Informant's Name/Relationship  | (Type, Print)  | 19b. Mai   | iling Address (Str   |  |  | ber, City or Town, St  | ate, Zip Code)  |
| other tre  |   | PATRICIA JEFF   | ERS/DAUGH  |  | RETINU   | JE_CT.   | #103, GW   | YNN OAK,   | MD 21207  |
|  |   | 20a. Method of Disposition 1 D Burial 2 D Cremation 3 [   | Removal from State   | 20b. Place of Disp<br>cemetery, cri  | position (Name o<br>rematory or other  | of .   | Date   | 20c. Location - Ci   | ity or Town, State  |
| important: I<br>eny injury o<br>once.  |   | 4 □Donation 5 □Other (Speci   | ify)   | METRO  | CREMAT   | ORY 1  | 2/22/05  | CATONS   | SVILLE, MD  |
| eny in   |   | 21. Signatur Peral Service Lice   | en see   |  | 22. Name and Ad  |  | HOWELL   | FUNERAL  | HOME 21207  |
| = • u  |   | 23a. Part Enjer the disease, or con   | 10.11  | ou in  | 4600 L   | IBERTY   | HEIGHTS  | AVE, BA  | ALTIMORE, M   |
| dical  |   | resulting in death)   | Due to for as a  | a consequence of):   | T-a; lar   | <u> </u>   |  |  | Onset and Death   |
| burial-transit   | cal Examiner  | Sequentially list conditions, if any, bearing to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  | Due to (er as e  | a consequence of): onsequence of): a consequence of):  | Toi, lin   |  |  |  | Onset and Death   |
| nysician and<br>he burial-transit  | Examin  | Sequentially list conditions, if any, bearing to immediate cause. Enter Underlying Cause (Disease or injury that initiated events   | c.  Due to (or as a  | a consequence of): onsequence of): a consequence of):  | Toi, lan   |  |  |  |   |
| attending physician and for use as the burial-transit  | Examin  | Sequentially list conditions, if any, leading to immediate cause. Enter Inderlying Cause (Disease or injury that initiated events resulting in death) Last  | Due to (er as e  | a consequence of):  onsequence of):  a consequence of):  of pregnancy  □ Fetal death 3   | Ectopic pregni   | ancy   |  | 23d. Date of Month   | of delivery   |
| igned by the attending physician and be detached for use as the burial-transit and   | by Physician/Medical Examin                                       | Sequentially list conditions, if day, leading to immediate cause. Enter Inderlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 220 No  | c. Due to (or as a d.  23c. If yes, outcome of the birth of the pregnant at th | a consequence of):  onsequence of):  a consequence of):  of pregnancy 2 □ Fetal death 3 time of death 5  | □Ectopic pregna<br>□ Other (specify  | ancy<br>V)   |  | Month tobacco use contribu   | of delivery  Day Year  ute to the cause of death?   |
| been signed by the arenibing physician and should be detached for use as the burial-transit  | by Physician/Medical Examin                                       | Sequentially list conditions, if any, leading to immediate cause. Enter Inderlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No 9 Unknown   | c. Due to (or as a d.  23c. If yes, outcome of the birth of the pregnant at th | a consequence of):  onsequence of):  a consequence of):  of pregnancy 2 □ Fetal death 3 time of death 5  | □Ectopic pregna<br>□ Other (specify  | ancy<br>V)   |  | Month tobacco use contribu   | of delivery  Day Year  ute to the cause of death?  Probably 4 Minknow   |
| nas been signed by the attending physician and in 2 should be detached for use as the burial-transit in a second by the second b | by Physician/Medical Examin                                       | Sequentially list conditions, if any, leading to immediate cause. Enter Inderlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No 9 Unknown   | c. Due to (or as a d.  23c. If yes, outcome of the birth of the pregnant at th | a consequence of):  onsequence of):  a consequence of):  of pregnancy 2 □ Fetal death 3 time of death 5  | □Ectopic pregna<br>□ Other (specify  | ancy<br>V)   | 24a. Wa  | tobacco use contributors 2 No 3 s an 24b. We price of the dear the | of delivery  Day Year  ute to the cause of death?  Probably 4 Nknow  or e autopsy findings availabor to completion of cause of  |
| ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit   | e Compieted by Physician/Medical Examin                           | Sequentially list conditions, if any feaching to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown  Part II. Other significant conditions   | c. Due to (or as a d.  23c. If yes, outcome of the birth of the pregnant at th | a consequence of):  onsequence of):  a consequence of):  of pregnancy 2 □ Fetal death 3 time of death 5  | □Ectopic pregna<br>□ Other (specify  | ancy<br>/)<br>e given in Part I.                                   | 24a. Wa<br>aute<br>per<br>1 D Yes  | tobacco use contribution of the contribution o | of delivery  Day Year  ute to the cause of death?  Probably 4 Nknow   |
| is definitioned has been signed by the attending physician and director, page 2 should be detached for use as the burial-transit and   | Be Completed by Physician/Medical Examin                          | Sequentially list conditions, if day, leading to immediate cause. Enter Inderlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown  Part II. Other significant conditions   | c. Due to (or as a d.  23c. If yes, outcome of the birth of the pregnant at th | a consequence of):  onsequence of):  a consequence of):  of pregnancy 2  | DEctopic pregna Other (specify underlying cause  | ancy<br>y)<br>e given in Part I.<br>26. Place o                    | 24a. Wa<br>auti<br>per<br>1 De Yes<br>f Death (Check only  | tobacco use contribution one)  Month  Month  Month  24b. We price dea 1 one)   | of delivery  Day Year  ute to the cause of death?  Probably 4 Nonknow  or eautopsy findings available of to completion of cause of the |
| is commonent as upon signed by the arching physican and director, page 2 should be detached for use as the burial-transit and  | To Be Completed by Physician/Medical Examin                       | Sequentially list conditions, if day, leading to immediate cause. Enter Inderlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown  Part II. Other significant conditions  25. Was case referred to medical examiner? 1  Yes 2 No 27. Manner of Death   | c. Due to (or as a d.  23c. If yes, outcome of the contributing to death but the contributing to death but the contribution the co | a consequence of):  onsequence of):  a consequence of):  of pregnancy 2   Fetal death 3 time of death 5  ut not resulting in the   | DEctopic pregna Other (specify underlying cause ent 3 DOA  | ancy<br>y)<br>e given in Part I.<br>26. Place o<br>Other: 4 □ Nurs | 24a. Wa<br>autu<br>per<br>1 D Yes<br>f Death (Check only<br>ing Home 5 Res   | tobacco use contribution of the contribution o | of delivery  Day Year  ute to the cause of death?  Probably 4 Nonknow  or eautopsy findings available of to completion of cause of the |
| director, page 2 should be detached for use as the burial transit  | To Be Completed by Physician/Medical Examin                       | Sequentially list conditions, if any feaching to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  | c. Due to (of as a d. 23c. If yes, outcome of library  | a consequence of):  onsequence of):  a consequence of):  of pregnancy 2   Fetal death 3 time of death 5  ut not resulting in the   | ent 3 DOA  | ancy<br>y)<br>e given in Part I.<br>26. Place o                    | 24a. Wa autu per 1 TY Yes f Death (Check only ing Home 5 Res 28d. Describe   | Month tobacco use contribution of the contribu | of delivery  Day Year  ute to the cause of death?  Probably 4 Minknow  or eautopsy findings available or to completion of cause of the  |
| is certificate has been signed by fite arientoning physician and director, page 2 should be detached for use as the burial-transit of  | To Be Completed by Physician/Medical Examin                       | Sequentially list conditions, if any, feaching to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   yes 2 No 9   Unknown  Part II. Other significant conditions  25. Was case referred to medical examiner? 1   yes 2 No 27. Manner of Death 1 Natural 5   Pending  | c. Due to (or as a d. 23c. If yes, outcome of the contributing to death but the contribution of  | a consequence of):  onsequence of):  a consequence of):  of pregnancy 2  | DEctopic pregnation of Laboratory of Laborat | ancy  26. Place o  Other: 4 Nurs  Injury at Work?  1 Yes 2 No      | 24a. Wa autu per 1 12 Yes f Death (Check only ing Home 5 Res   | tobacco use contributions and commed? 24b. We price dea commed? 2 \( \text{No} \) 1 \( \text{Onne} \) idence 6 \( \text{Other} \) thow injury occurred   | of delivery  Day Year  ute to the cause of death?  Probably 4 Minknow  or eautopsy findings available or to completion of cause of the  |
| In uneral burector: After this certificate has been signed by the attending physician and stelly filled in by the funeral director, page 2 should be detached for use as the burial-transit and  | Certification; To Be Completed by Physician/Medical Examin        | Sequentially list conditions, if any, feaching to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   yes 2   No 9   Unknown  Part II. Other significant conditions  25. Was case referred to medical examiner? 1   yes 2   No  27. Manner of Death 1   Natural   5   Pending investigation   21   Accident   3   Suicide   4   Homicide   1   Certifying P | C. Due to (of as a d. 23c. If yes, outcome of light with the pregnant at 9 Unknown contributing to death but the light with th | a consequence of):  onsequence of):  or pregnancy 2   Fetal death 3 time of death 5  ut not resulting in the  or year)   28b. Time Injury  or year, At home, farm, sexamination and/or in the examination and/or in the examinatio | ent 3 DOA of 28c. I  | ancy  26. Place o  Other: 4 Nurs  Injury at Work? 1 Yes 2 No       | 24a. Wa autroper 1 1 2 Yes of Death (Check only ing Home 5 Res 28d. Describe 28f. Location City or To  | Month  tobacco use contribution  Yes 2 No 3  s an 24b. We price of 22 No 1  one)  sidence 6 Other how injury occurred  (Street and Number own, State)  | of delivery Day Year  ute to the cause of death? Probably 4 Nnknow  or e autopsy findings available or to completion of cause of the 2 No  (Specify)  or Rural Route Number,  |
| Atter this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-transit and  | To Be Completed by Physician/Medical Examin                       | Sequentially list conditions, if any feeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   | C. Due to (of as a d.  23c. If yes, outcome of the contributing to death but the contribution the contributi | a consequence of):  onsequence of):  or pregnancy 2   Fetal death 3 time of death 5  ut not resulting in the  or year)   28b. Time Injury  or year, At home, farm, sexamination and/or in the examination and/or in the examinatio | ent 3 DOA of 28c. I  | ancy  26. Place o  Other: 4 Nurs  Injury at Work? 1 Yes 2 No       | 24a. Wa autoper 1 De Yes f Death (Check only ing Home 5 Res 28d. Describe 28f. Location City or Toplace, and due to the occurred at the time | Month  tobacco use contribution  Yes 2 No 3  s an 24b. We price dea 2  Z No 1  one)  sidence 6 Other on the minimal occurred  (Street and Number own, State)  e cause(s) and mann, date and place, and   | of delivery Day Year  ute to the cause of death? Probably 4 Nicknow or autopsy findings available of to completion of cause of th? I'ves 2 No  (Specify)  or Rural Route Number, er as stated. d due to the cause(s)  Month, Day, Year)   |
| In uneral burector: After this certificate has been signed by the attending physician and stelly filled in by the funeral director, page 2 should be detached for use as the burial-transit and  | edical Certification; To Be Completed by Physician/Medical Examin | Sequentially list conditions, if any feaching to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  | C. Due to (of as a d.  23c. If yes, outcome of the contributing to death but the contribution the contributi | a consequence of):  onsequence of):  or pregnancy 2   Fetal death 3 time of death 5  ut not resulting in the  or year)   28b. Time Injury  or year, At home, farm, sexamination and/or in the examination and/or in the examinatio | ent 3 DOA of 28c. I  | ancy  26. Place o  Other: 4 Nurs  Injury at Work? 1 Yes 2 No       | 24a. Wa autoper 1 De Yes f Death (Check only ing Home 5 Res 28d. Describe 28f. Location City or Toplace, and due to the occurred at the time | Month  tobacco use contribution  Yes 2 No 3  s an 24b. We price dea 2  Z No 1  one)  sidence 6 Other on the minimal occurred  (Street and Number own, State)  e cause(s) and mann, date and place, and   | of delivery Day Year  ute to the cause of death? Probably 4 Ninknown or e autopsy findings available of to completion of cause of th? Yes 2 No  (Specify)  or Rural Route Number, er as stated. d due to the cause(s)  Month, Day, Year)  |
| In uneral burector: After this certificate has been signed by the attending physician and stelly filled in by the funeral director, page 2 should be detached for use as the burial-transit and  | edical Certification; To Be Completed by Physician/Medical Examin | Sequentially list conditions, if any feaching to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  | Due to (of as a d.  23c. If yes, outcome of the limit of  | a consequence of):  onsequence of):  or pregnancy 2   Fetal death 3 time of death 5  ut not resulting in the  nt 2   ER/Outpatie y year)   28b. Time Injury  of my knowledge, dea examination and/or i   | ent 3 DOA of 28c. I  | ancy  26. Place o  Other: 4 Nurs  Injury at Work? 1 Yes 2 No       | 24a. Wa autoper 1 De Yes f Death (Check only ing Home 5 Res 28d. Describe 28f. Location City or Toplace, and due to the occurred at the time | Month  tobacco use contribution  Yes 2 No 3  s an 24b. We price dea 2  Z No 1  one)  sidence 6 Other on the minimal occurred  (Street and Number own, State)  e cause(s) and mann, date and place, and   | of delivery Day Year  ute to the cause of death? Probably 4 Nnknow  or autopsy findings available to completion of cause of the cause (s)  |

|                     |   |                     | For  | State of Maryland / Depa  |  | Mental Hygier                        | ne O O E                                  | 1 1  |
|---------------------|---|---------------------|--|---|--|--------------------------------------|---|--|
|                     |   |                     | State Registrar     Decedent's Name (First, Middle, Last)  | Ce  | rtificate of Death   | Reg.                                 | 0 U U 201                                 | 4 650  |
|                     | Physicia<br>/Medic  |                     | WANDA  | BRUNK   |  | Month I                              | Day Year<br>21, 2005                      | 4:45 P. M.   |
|                     | Examin  |                     | 4a. Facility Name (If not institution, give s  |   | 4b. City, Town, or Location of Death   | 1                                    | 4c. County of Death                       | ,            |
|                     |   |                     | FOREST HILL HEALTS  5. Social Security Number 6. Sex   |   | FOREST HILL  If Under 1 Year   If Under 24 Hrs.                                | O Data of Birth                      | HARF                                      |  |
|                     | Funeral<br>Director   |                     |  | M 2 K F Yrs.  | Months Days Hours Min.   | 8. Date of Birth<br>(Month, Day, Yes |   | lace (State or Foreign<br>try)                     |
|                     | pu *  |                     | Usual Residence of Decedent  10a. State 10b. County  | 10c. City, Town or Lo   |  | 0 1- 2                               | /   |  |
|                     | Maryla<br>fed at  | jo                  | MN 1125Fo  |   | prest Hill   |                                      | 1   | 0d. Inside City Limits 1 ☐ Yes 2 No                |
|                     | or 28a  | irec                | 10e. Street and Number   | 14  | 10f. Zip Code  | 10g.                                 | Citizen of What Coun                      | try?   |
|                     | permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hylgiene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examination and item and item and income. | by Funeral Director | 109 Forest Vall  | ey DR.  | 21050  |                                      | USA                                       |  |
|                     | ter de  | -une                | 11. Marital Status  1 ☐ Never Married 2 ☐ Married  | 12. Was Decedent Ever in U.S. Armed Forces?  1 Yes 2 No                             | Was Decedent of Hispanic Origin? (Sp<br>If Yes, specify Cuban, Mexican, Puerto | ecify Yes or No-<br>Rican, etc.)     | 14. Race - Americ<br>Black, White,        |  |
| 99                  | ours af   | by                  | 3 Widowed 4 Divorced   | If Yes, Give<br>Year or Dates:  | 1 ☐ Yes 2 No Specify:  |                                      | Specify: W                                | rite.  |
| Maryland 21215-0036 | "natu   | Completed           | 15. Decedent's Educ<br>(Specify only highest grade   | (Give   | dent's Usual Occupation<br>kind of work done during most of work               | ting 16b.                            | . Kind of Business/Ind                    | dustry   |
| 7                   | iene.   | dmo                 | Elementary/Secondary (0-12)  | College (1-4or5+)   | DO NOT use retired)  | N                                    | nio Unive                                 | ceitu  |
| פ                   | e filed<br>al Hyg<br>other<br>vant,   | BeC                 | 17. Father's Name (First, Middle, Last)  | , NO  |  | e (First, Middle, Maid               |   | 12114  |
| <u>yaı</u>          | Menta<br>Menta<br>Merked<br>Marked  | To                  | John Simon   |   | Wand   | a Bro.                               | ZOWSKI                                    | •  |
| Mar                 | d 2 sh<br>th and<br>7 Is m<br>traum   |                     | 19a. Informant's Name/Relationship (Type   | 19b. Mailir   | ng Address (Street and Number or Rui   | $\supset$ $\sim$ .                   |   | Code)  |
| <u>6</u>            | s 1 an<br>f Heall<br>Item 2<br>other  |                     | 20a. Method of Disposition   | 20b. Place of Dispo   | osition (Name of   |                                      | Location - City or To                     | wn, State  |
| Ē                   | Pages<br>nent of<br>nnt: If I   |                     | 1 ☐ Burial 2 ☐ Cremation 3 ☐ Re '4 ☐ Donation 5 ☐ Other (Specify)  | emoval from State  Fuans Fun  | matory of other place  | 23-05 FO                             | cest Hill                                 | MAC  |
| Baltimore,          | permit. Departn Imports any inju  |                     | 21. Signature of Funeral Service License   |   | 2. Name and Address of Facility  | RESTHIL                              | JMD 210                                   |  |
| _                   | 40 E 8 9  | _                   | Symboly 4-   | surolay Ev  | ANS FUNERAL CH   | PEL-BELL                             | FIR, 3 NEL                                |  |
|                     |   |                     | shock, or heart failure. List only on  | cations that caused the death. Do not ent<br>e cause on each line.                  | 1 - 0  | or respiratory arrest,               |   | Approximate<br>Interval Between<br>Onset and Death |
|                     | Physician<br>/Medical   |                     | disease or condition resulting in death)   | Due to (or as a consequence of):  | al dement  | 2                                    |   |  |
|                     | Examiner  |                     | Sequentially list conditions b   |   |  |                                      |   |  |
| /                   | ed<br>sit   | iner                | Sequentially list conditions, if a ny, leading to immediate cause. Enter Underlying Cause (Disease or injury | Dualto (or as a nonsequence of):  |  |                                      | 1   |  |
|                     | s be executed<br>sician and<br>burlal-transit   | Examiner            | that initiated events resulting in death) Last   | Due to (or as a consequence of):  |  |                                      |   |  |
| 8760,               | sate be executed obysician and the burial-transit   | dical               | d.   |   |  |                                      |   |  |
| 89 ×                | entifica<br>ling ph<br>e as th  | Med                 | IF FEMALE:   |   |  |                                      |   | -  |
| Вох                 | attending p   | Physician/Me        | in the past 12 months?   |   | Ectopic pregnancy Other (specify)  |                                      | 23d. Date of deliver<br>Month             | ry<br>Day Year                                     |
| o.                  | t the d<br>by the<br>ached  | hysi                | 1 ☐ Yes 2 ☑ No<br>9 ☐ Unknown  | 9□ Unknown  | Garar (speedily)   |                                      |   |  |
| S,                  | as t  | by P                | Part II. Other significant conditions conf   | tributing to death but not resulting in the ur                                      | ndertying cause given in Part I.   | 23e. Did tobacci                     | o use contribute to the                   | e cause of death?                                  |
| ord                 | w require<br>been sig<br>should b   |                     |  |   |  | 1 Tes                                | 2 No 3 Proba                              | ably 4 QUnknown                                    |
| Vital Records,      | has t   | Completed           |  |   |  | 24a. Was an autopsy performed?       | 24b. Were autop<br>prior to com<br>death? | sy findings available appletion of cause of        |
|                     |   | 0                   | 25. Was case referred to medical   |   | 26 Place of Deat   | 1 Yes 2 St                           | Vo 1 ☐ Yes                                | 210 No   |
| <u> </u>            | Physician:<br>r this certific<br>ral director,  | To B                | examiner? 1 Yes 2 No   | ospital: 1   Inpatient 2   ER/Outpatien   |  | me 5 Residence                       | 6 ☐Other (Specify                         | )  |
| Division of         | ttanding Phydeath.<br>tor: After thinthe funeral  |                     | 27. Manner of Death 1 Natural 5 □ Pending  | 28a. Date of Injury (Month, Day Year) 28b. Time of Injury                           | 28c. Injury at<br>Work?  | 28d. Describe how in                 |   |  |
| Sic                 | l or Attanding<br>after death.<br>Director: After<br>in by the fune   | licat               | 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be  | 28e. Place of Injury - At home, farm, str   | M 1 Yes 2 No   | 28f. Location (Street)               | and Number or Rural                       | Pouto Number                                       |
| <u>≥</u>            | al or Att   | Certification:      | 4 Homicide determined  | building, etc. (Specify)  | cot, ladory, onles   | City or Town, Sta                    | ite)                                      | noute wanter,                                      |
|                     | Hospita<br>24 hours<br>Funaral<br>tely filled   |                     | 29a. Certifier (Check only 2 Medical Examin  | ician: To the best of my knowledge, deather: On the basis of examination and/or inv | occurred at the time, date and place,  | and due to the cause                 | (s) and manner as sta                     | ated.  |
|                     | To the Hospital within 24 hours a To the Funaral I completely filled  | Medical             | one)  29b. Signature and title of certifier  | and manner stated.  | 29c. License number  |                                      | Date signed (Month, D                     |  |
|                     | £ ₹ 50  |                     | 10 110   |   |  |                                      |   |  |
|                     | N   |                     | 30. Name and address of person who cor   | mpleted cause of death (Item 23a) (Type,  | 13322))<br>Print)  | 126                                  | cember                                    | 22,000   |
|                     | .,  |                     | DR. DAVID DUNN -   | 615 W. MACPHAIL RO  | OAD - BEL AIR, N   | D. 21014                             |   |  |
|                     | Stat<br>Registra  | -                   | 31. Date filed (Month, Day Fyear) 2 7  | 615 W. MACPHAIL RO  | books  |                                      |   |  |

| S. Carlot                |  |                  | 1 - For<br>State<br>Registrar  |  |                                    | partment of Health<br>ertificate of Death   | ר   | Reg. No                                | 11113   | 41651  |
|--------------------------|--|------------------|--|--|------------------------------------|---|---|--|---|--|
| 1                        | Physic   |                  | 1. Decedent's Name (First, Middle, La<br>Mary Adele Bayne  | st)  |                                    |   | 2. Date of DECEN                                  |  | , 200e  | 3. Time of Death  0.06:35 A                        |
|                          | /Medi<br>Exami   |                  | 4a. Facility Name (If not institution, gives   | e street and number)   | Center                             | 4b. City, Town, or Location   |   |  | . County of Death                                     | imore  |
|                          | Funeral<br>Director  |                  | 200 20 1707  | Sex 7. Ag  | e (In yrs. last birthda<br>80 Yrs. | If Under 1 Year If Under Months Days Hours  | Min. 8. Date o                                    | f Birth<br>, <i>Day</i> , <i>Year)</i> | 1005  | place (State or Foreign<br>ntry)                   |
|                          | anyland<br>ehow  |                  | Usual Residence of Decedent  10a. State 10b. County  |  | 10c. City, Town or                 | ocation   |   |  | 1   | IOd. Inside City Limits                            |
|                          | a-feh  | ctor             | Maryland Baltimo   | ore  | Cockeysv                           | ille  |   |  |   | 1 ☐ Yes a No                                       |
|                          | vith th  | Dire             | 10e. Street and Number   |  |                                    | 10f. Zip Code   |   | 10g. Cit                               | izen of What Cour                                     | ntry?  |
|                          | leath v  | Funeral Director | 10531 Howard Aver  | 1UE<br>12. Was Decedent  | Ever in H.S. 13                    | 21030   | sining (Const. Was a                              |  | ited Stat   |  |
| 21215-0036               | d within 72 hours after death with the Maryland jiene. rithan "natural", or Itame 23a or 28a-f ehow tre Maryland Examination from the notified at  | by               | 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced   | Armed Forces?  1 ☐ Yes 2 ☐ N  If Yes, Give X  Year or Dates:             | lo                                 | Was Decedent of Hispanic On If Yes, specify Cuban, Mexical 1 ☐ Yes XX No Specify  |   | )                                      | 14. Race - Americ<br>Black, White,<br>Specify:<br>Whi | etc.   |
| 15-0                     | natu   | letec            | 15. Decedent's E   | ducation<br>de completed)  | 16a. Dec                           | edent's Usual Occupation<br>e kind of work done during mo.<br>DO NOT use retired) | st of working                                     | 16b. K                                 | ind of Business/Ind                                   |  |
| 12                       | withir<br>iene.<br>then  | Completed        | Elementary/Secondary (0-12)  | College (1-4or 5<br>(N/A)  | +)                                 | ol Crossing Gu  |   | Pol+i                                  | mara Car  | inty School  |
| nd ?                     | be filed<br>ital Hygi<br>id other  | BeC              | 17. Father's Name (First, Middle, Last,  |  | Bello                              |   | er's Name (First, Mic                             |  |   | itty school  |
| Maryland                 | 2 should be filed within<br>and Mental Hygiene.<br>Is marked other than<br>aumatic event, tre Mi   | To               | Anthony Blaski   |  |                                    |   | ia Mika   |  |   |  |
| Mar                      | s 1 and 2 should<br>f Health and Men<br>itam 27 Is marke<br>other traumatic  |                  | 19a. Informant's Name/Relationship (   |  |                                    | ing Address (Street and Numb  |   |  |   |  |
|                          | s 1 and 2<br>of Health<br>item 27 I  |                  | Mr. Henry F. Bayne  20a. Method of Disposition   |  | 20b. Place of Disc                 | 1 Howard Ave.   | Cockeysvi   |  | ryland,   |  |
| Baltimore,               | permit. Pages to Department of Pluportent: If its any injury or ot ong.  |                  | XXX Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif  | Removal from State   | _                                  | Walley Mem.   | 12/27/05  |  | onium   | m, otato   |
| Balti                    | permit. Departn Imports any inju   |                  | 21. Signature of Funeral Service Licer   |  |                                    | 2. Name and Address of Facili<br>eaceful Altern<br>325 Vorla Pond                 |   |  |   | - Ct D A   |
| -5                       | ₹0 E # 9   |                  | Law of I   | n gran   |                                    | JAJ TULK KUAU   |   | Marvia                                 | nd, 2109  | 3 Ctr.P.A.   |
|                          | A. T   |                  | 23a. Part1. Enter the disease, or com<br>shock, or heart failure. List only<br>Immediate Cause (Final    |  |                                    |   | s cardiac or respirator                           | y arrest,                              |   | Approximate<br>Interval Between<br>Onset and Death |
| F. a.                    | Physician<br>/Medical  |                  | disease or condition resulting in death)   | a. PULMON  | ARY EMBC                           | L. I.   |   |  |   |  |
| 1                        | Examiner   |                  | Sequentially list conditions,  | I SCHEM  | IA                                 |   |   |  |   |  |
|                          | ed sit   | nine             | if any, leading to immediate cause. Enter Underlying Cause (Disease or injury                            | -  | consequence of):                   |   |   |  |   |  |
| ,                        | ificate be executed<br>g physicien and<br>as the burial-transit  | Examiner         | that initiated events<br>resulting in death) Last  | c. ASYSTO  Due to (or as a   | consequence of):                   |   |   |  |   |  |
| 68760,                   | ysicle   | edical           |  | . d  |                                    |   |   |  |   |  |
|                          | - CO -   |                  | IF FEMALE:   |  |                                    |   |   |  |   |  |
| P.O. Box                 | To the Hospital or Attanding Physician: The law requires that the death certif within 24 hours after death. within 24 hours after death. to the Funeriel Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use a | Physiclan/M      | 23b. Was decedent pregnant in the past 12 months?  1 □ Yes 2 No 9 □ Unknown                              | 23c. If yes, outcome of 1 □ Live birth 1: 4 □ Pregnant at 1: 9 □ Unknown | 2 ☐ Fetal death 3                  | □Ectopic pregnancy □ Other (specify)  |   | - 2                                    | 3d. Date of deliver<br>Month                          | ry<br>Day Year                                     |
| S,<br>CT                 | es that<br>gned b  | by PI            | Part II. Other significant conditions of   | ontributing to death bu  | t not resulting in the             | inderlying cause given in Part I  | . 23e. D  | id tobacco u                           | se contribute to the                                  | e cause of death?                                  |
| ord                      | requir<br>een si<br>ould I   | ted              |  |  |                                    |   |   | □Yes 2[                                | □No 3 □ Proba   | ably 4 Unknown                                     |
| Division of Vital Record | he law   | Completed        |  |  |                                    |   | 24a. W  | itopsy                                 | prior to com  | sy findings available apletion of cause of         |
| la                       | Physician: The lav<br>this certificate hes<br>al director, page 2  | e Co             | 25. Was case referred to medical   |  |                                    |   | 1 □ Ye  |  | death?  | 2 <b>X</b> No                                      |
| Ž                        | ysicie<br>iis cert<br>direct   | To B             | examiner?  | Hospital: 1 Inpatier   | t 2 ER/Outpatie                    | Other   | of Death   Check on                               |  | Other (Secret   | 1  |
| 0                        | ng Ph<br>Ifter th  | uo:              | 27. Manner of Death 1. Natural 5 ☐ Pending   | 28a. Date of Injury<br>(Month, Day                                       | 28b. Time o                        |   | 28d. Descrit                                      |  |   |  |
| <u>S</u>                 | ttendi<br>death.<br>:tor: A<br>the fu  | cati             | 2 Accident investigation 3 Suicide 6 Could not be  |  |                                    | M 1 Yes 2   |   |  |   |  |
| Ω                        | rs after<br>rs after<br>el Dirac<br>ed in by   | Certification:   | 4 ☐ Homicide determined  | building, etc.   | y - At home, farm, st<br>(Specify) | eet, factory, office  | 28f. Location<br>City or                          | n (Street and<br>Town, State)          | Number or Rural                                       | Route Number,                                      |
|                          | To the Hospitel or Attanding Ph<br>Within 24 hours after death.<br>To the Funerel Diractor: After th<br>completely filled in by the funeral  | edical           | 29a. Certifier (Check only one) Certifying Phyone) Certifying Phyone 2 Medical Exemples (Check only one) | vsician: To the best of iner: On the basis of and manner stat            | examination and/or in              | h occurred at the time, date an<br>vestigation, in my opinion, dea                | d place, and due to the the decourred at the time | ne cause(s) a<br>e, date and           | and manner as sta<br>place, and due to                | ted.<br>the cause(s)                               |
|                          | Tot<br>Tot<br>Com  | Σ                | 29b. Signature and title of certified  |  |                                    | 29c. License number   |   | 29d. Date                              | signed (Month, D                                      | ay, Year)  |
| )                        |  | -                | h. No  | 1  |                                    | D46356  |   | Dece                                   | mber 23   | , 2005   |
|                          | り  |                  | 30. Name and address of person who of<br>KHOSROW TABASS  |  |                                    |   | OHOOM NAC   | F5171 75                               | 10 00 2 00 00   | ,  |
|                          | Sta  | ~                | 31. Date filed (Month, Day, Year)  | 32. Registrar  | 's Signature                       |   | OWSON, MC   | 1 FY Y L. F-1                          | AD 5150   | £4   |
|                          | Registra   |                  | DEC 2 7 2  | 2005 Block   | w # A                              | parke   |   |  |   |  |
| DHM                      | H 17 Rev 1/20  | 01               |  |  |                                    |   |   |  |   |  |

|                |   |                           |   | partment of Health and Mental Hygie<br>ertificate of Death  | 7001 4 1017                                       |
|----------------|---|---------------------------|---|---|---|
|                | Physici   | an                        | Decedent's Name (First, Middle, Last)   | 2. Date of Death<br>Month   | Day Year 3. Time of Death                         |
|                | Physici<br>/Medic   |                           | ANNA BATEMAN  |   | 24, 2005 8:15 P. M.                               |
|                | Examir  | er                        | 4a. Facility Name (If not institution, give street and number)  |   | 4c. County of Death                               |
|                |   |                           | FOREST HILL HEALTH  5. Social Security Number 6. Sex 7. Age (In yrs. last birthda   | FOREST HILL y) If Under 1 Year   If Under 24 Hrs.   8 Date of Birth   | HARFORD   |
|                | Funeral<br>Director   |                           | 5. Social Security Number 6. Sex 7. Age (In yrs. last birthda   | Months Days Hours Min. (Month, Day, Ye  |   |
|                | D   |                           | Usual Residence of Decedent   | Feb. 20, 1  | 928 Delaware                                      |
|                | nylan<br>show   | _                         | 10a. State 10b. County 10c. City, Town or   | Location  | 10d. Inside City Limits                           |
|                | Ba-f e  | Director                  | MD BALTIMORE. Bati  | noke  | 1 ☐ Yes 23 No                                     |
|                | with th   | E                         | 10e. Street and Number  |   | Citizen of What Country?                          |
|                | eath 1  | erai                      | 11. Marital Status 12. Was Decedent Ever in U.S. 1  | 1 21322 (   | USA   |
|                | fter d  | Funerai I                 | 11. Marital Status  12. Was Decedent Ever in U.S. 1 Armed Forces?  1 □ Never Married 2 ☑ Married 1 □ Yes 2 ☑ No                           | Was Decedent of Hispanic Origin? (Specify Yes or No-<br>If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian,<br>Black, White, etc. |
| 98             | hours after death with the Maryland<br>turel', or Items 23e or 28e-f ehow<br>al Examinat must be notified at      | ρ                         | 3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:  | 1 ☐ Yes 2 ☑ No Specify:   | Specify:  |
| 215-0036       | 72<br>E 38  | Completed                 | 15. Decedent's Education 16a. De (Specify only highest grade completed) (Gi   | cedent's Usual Occupation  ve kind of work done during most of working                                      | . Kind of Business/Industry                       |
| 2              | within lene.  | mpi                       | Elementary/Secondary (0-12) College (1-4or 5+)  | . DO NOT use retired)   | N   |
| 121            | filed v<br>I Hygie<br>other t   |                           | 17. Father's Name (First, Middle, Last)   | utive Housekeeper A   | partment Communi                                  |
| and            | be od o   | Be c                      | 0 - 1 -   | 18. Mother's Name (First, Middle, Maid  | den Sumame)                                       |
| Maryland       | 2 should be<br>and Menta<br>Is marked<br>sumatic ev   | L<br>C                    | Raymond Sproul, SR<br>19a. Informant's Name/Relationship (Type, Print) 19b. Ma  | Nellie Lewis iling Address (Street and Number or Rural Route Number, Cit                                    | ty or Town State Zin Code)                        |
| Ž              | nd 2<br>lith a<br>27 Is   |                           |   |   | nure Maryland 21222                               |
| altimore,      | es 1 au<br>of Hea<br>fitem<br>rothe   |                           | 20a. Method of Disposition 20b. Place of Dis  |   | . Location - City or Town, State                  |
| Ē              | Pages<br>nent of<br>ant: If it<br>ary or o  |                           | 1 18 Burial 2 □ Cremation 3 □ Removal from State  1 19 Burial 2 □ Cremation 3 □ Removal from State  1 10 Donation 5 □ Other (Specify)     | Memorial Gordons Dec. 28,2005 M   | iddle River Marked                                |
| alt            | permit. Pages<br>Department of<br>Important: If i<br>any injury or once   |                           |   | 22. Name and Address of Facility 200 Evons  | chapel of Memories                                |
| 8              | 207 2 2   |                           | Thucky G. Surother  | 800 Harford Road Parkvil  | He Maryland 21234                                 |
| П              |   |                           | 23a. Part1. Enter the disease of complications that caused the death. Do not e shock, or heart failure, List only one cause on each line. | nter the mode of dying, such as cardiac or respiratory arrest,  | Approximate<br>Interval Between                   |
| k              | Physician   |                           | Immediate Cause (Final disease or condition resulting in death)   | tenders pulmony de  | Onset and Death                                   |
|                | /Medical<br>Examiner  |                           | Due to (or as a consequence of):  | 0   |   |
|                |   | er                        | Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):  |   |   |
| 1              | d<br>d<br>ansit   | Examiner                  | if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events                                       |   |   |
| o,             | an an   |                           | resulting in death) Last Due to (or as a consequence of):   |   |   |
| 8760,          | cate be executed<br>physician and<br>the burial-transit   | dicai                     | d   |   |   |
| 9<br>×         | entific<br>ding p   | Mec                       | IF FEMALE:  |   |   |
| Вох            | leath certifi<br>attending  | ian                       | A Decement at time of death   | Ectopic pregnancy   | 23d. Date of delivery  Month Day Year             |
| o.             | that the de<br>ed by the<br>detached  | ysic                      | 1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 5 9 ☐ Unknown 9 ☐ Unknown  | Other (specify)   |   |
| σ.             | The law requires that the death certificate has been signed by the attending page 2 should be detached for use as | Completed by Physician/Me | Part II. Other significant conditions contributing to death but not resulting in the  | underlying cause given in Part I. 23e. Did tobacc   | o use contribute to the cause of death?           |
| ğ              | w requires that<br>been signed to<br>should be det  | ed b                      | poluony embles  | 1 🗆 Yes   | 2 No 3 Probably 4 Unknown                         |
| 900            | e law re<br>has bee   | plet                      | Pessello huy mas  | 24a. Was an   | 24b. Were autopsy findings available              |
|                |   | Com                       | )   | autopsy<br>performed'<br>1 ☐ Yes 2 1 ☐ Yes  |   |
| Vital Records, | cien<br>ertifi<br>ector   | Be                        | 25. Was case referred to medical examiner?  | 26. Place of Death (Check only one)   |   |
| of             | hye<br>his  | 2                         | 1 Yes No Hospital: 1 Inpatient 2 ER/Outpati   |   |   |
| no             | tending I<br>leath.<br>tor: After<br>the funer  | tion                      | 27. Manner of Death  Natural 5 □ Pending (Month, Day Year)  Natural investigation (Month, Day Year)                                       | of 28c. Injury at Work?  M 1 \( \text{Yes} 2 \) No  | jury occurred                                     |
| Division       | l or Attending<br>after death.<br>Director: After<br>I in by the fune   | fica                      | 3 Suicide 6 Could not be 28e. Place of Injury - At home farm  |   | and Number or Rural Route Number.                 |
| 2              | al or s<br>after<br>I Dire<br>d in b  | Certification;            | 4 Homicide determined building, etc. (Specify)  | City or Town, Sta   |   |
|                | Hospitel or A 24 hours after Funerel Dire stely filled in by  |                           | 29a. Certifier Check only 2 Medical Examiner: On the basis of examination and/or  | ath occurred at the time, date and place, and due to the cause  | (s) and manner as stated.                         |
|                | To the Hospitel or At within 24 hours after of To the Funerel Direct completely filled in by                      | Medical                   | (Check only one)  2 Medical Examiner: On the basis of examination and/or and manner stated.   | nvestigation, in my opinion, death occurred at the time, date a   | and place, and due to the cause(s)                |
|                | To the within 2 To the complet  | 2                         | 29b. Signature and title of certifier   | 29c. License number 29d. D  | Date signed (Month, Day, Year)                    |
|                | 1   |                           | David 5 D   |   | ecember 27,200                                    |
|                | b   |                           | 30. Name and address of person who completed cause of death (Item 23a) (Type DR. STANLEY KMAN - 1308 RISTNESS CEN                         | , Print)  | , ,   |
|                | Sta   | e                         | 31 Date filed (Month Day Year) 32 Printer's Signature   | TIER WAY - EDGEWOOD, MD 21040   | )   |
| 14             | Registra  | 7                         | 31. Date filed (Month, Day, Year) DEC 2 7 2005 32. Pigistrar's Signature  |   |   |

| Please Type or Print in Black Indelible Ink | . Ensure All Copies Are Legible |
|---|---------------------------------|
| • •   |                                 |

|             |   |                  | For  | •   |  | ent of Health and   |  | •   | 1.1653  |
|-------------|---|------------------|--|---|--|---|--|---|---|
|             |   |                  | 1 - State<br>Registrar   |   | Certific                                       | ate of Death  | 1  | . No.                                     | 41000   |
|             | Physici<br>/Medic<br>Examin   | al               | 1. Decedent's Name (First, Middle, Lasi  |   | Bell Bell                                      | City, Town, or Location of Deat   | 2. Date of Death Month                           | Day Year<br>23 2005<br>4c. County of Deat | 3. Time of Death 9.30A M  |
| **          | Funeral<br>Director   | 27%              | 5. Social Security Number 6. Se 192-16-5779 15 Usual Residence of Decedent   | X Age (In yrs   | s. /ast birthday) If U<br>Mor                  | nder 1 Year If Under 24 Hrs<br>ths Days Hours Min.                                  | 8. Date of Birth                                 | 9. Birt                                   | holde (State or Foreign   |
|             | e Maryland<br>la-f show   | ctor             | 10a. State 10b. County  Baltima  | 10c. C  | City, Town or Location                         | imonium   |  |   | 10d. fnside City Limits<br>1 ☐ Yes 2 No                           |
|             | sath with the   | eral Director    | 10e. Street and Number 2300 Dubno  | zy Valley   | Kd   | 21093   |  | Citizen of What Co                        |   |
| 5-0036      | hours after death with the Maryland<br>turel', or Items 23a or 28a-f show<br>at Examination invitied at                                     | by Funeral       | 11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  | 12. Was Decedent Ever in<br>Armed Forces?<br>1 Pes 2 V No<br>If Yes, Give<br>Year or Dates: | ff Yes   | ecedent of Hispanic Origin? (S<br>specify Cuban, Mexican, Puer<br>es 27 No Specify: | to Rican, etc.)                                  | Specify: White                            |   |
| D-CLZL2     | within 72<br>ane.<br>than "nei  | Completed        | 15. Decedent's Edi<br>(Specify only highest grad   | ucation<br>de completed)<br>Coffege (1-4or 5+)  | 16a. Decedent's (Give kind of life. DO No.     | Usual Occupation<br>If work done during most of wo<br>DT use retired)               | rking 16   | A Poil Co                                 | Industry  |
| yland       | should be filed<br>ind Mental Hygid<br>marked other<br>umatic event, II   | To Be C          | 17. Father's Name (First, Middle, Last) Gerald Cho   |   | nes  | Matilo  | me (First, Middle, Ma                            | e Gai                                     | dus   |
| e, Mary     | 1 and 2<br>Health a<br>em 27 ls   |                  | 19a. Informant's Name/Relationship (T  | 57  |  | liess (Street and Number or Ri<br>(Name of  | Timonio  | City or Town, State, 2                    | 21093   |
| Baltimore,  | permit. Pages<br>Department of<br>Important: If it<br>eny injury or o   |                  | 1 Burial 2 Cremation 3 1 4 Donation 6 Other (Specify, 21. Signature Funeral Service Litense  | EVO   | cemetery, crematory  21 SFUNE IN 22. Nan       | Charlet 12/a  | 17/05 F  | orest Hi                                  | ill MD  |
| n           | 80 E 8  |                  | 23a. Part 1. Enter the disease, of comp<br>shock, or heart failure. List only of<br>fmmediate Cause (Final   | plications that caused the deprine cause or each line.                                      | ath. Do not enter the                          | FULA (TFENA)<br>mode of dying, such as cardia                                       |  |   | MAPUN CEVIE<br>Approximate<br>Interval Between<br>Onset and Death |
|             | Physician<br>/Medical<br>Examiner   |                  | disease or condition resulting in death)   | a. CHRONIC OBS  |  | ULMONARY DISEA  | SE   |   |   |
| 3/60,       | ate be executed sysicien and he burial-transit  | ical Examiner    | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | c.  Due to (or as a conse   |  |   |  |   |   |
| O. Box 68   | requires that the death certifica<br>een signed by the attending ph<br>hould be detached for use as th                                      | by Physician/Med | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ▼ No 9 □ Unknown  | 23c. If yes, outcome of preging 1 Live birth 2 □ Fe 4 □ Pregnant at time of 9 □ Unknown     | tal death 3 Ector                              | pic pregnancy<br>r (specify)  |  | 23d. Date of del<br>Month                 | ivery<br>Day Year   |
| rds, P      | w requires that<br>been signed b<br>should be deta  |                  | Part II. Other significant conditions co   | ontributing to death but not re   | esulting in the underly                        | ing cause given in Part I.  |  |   | the cause of death?   |
| al Kecords, | The law<br>ite has b  | Completed        |  |   |  |   | 24a. Was an autopsy performe                     | prior to death?                           | itopsy findings available<br>completion of cause of<br>2  No      |
| VItal       | Physiclan:<br>r this certifice<br>rral director, p  | o Be             | 25. Was case referred to medical examiner?  1 Yes 2 No   | Hospital: 1 Inpatient 2   | ☐ ER/Outpatient 3[                             | Othor   | ath (Check only one)                             | 2 5000000                                 |   |
| ion of      | ending Phy<br>ath.<br>or: After this  | $\vdash$         | 27. Manner of Death 1 X Natural 5 Pending 2 Accident investigation   | 28a. Date of Injury<br>(Month, Day Year)  | 28b. Time of Injury                            | 28c. Injury at Work? 1 Yes 2 No   | 10me 5 Resident<br>28d. Describe how             |   | city)   |
| Division    | To the Hospital or Attending Ph<br>within 24 hours after death.<br>To the Funeral Director: After th<br>completely filled in by the funeral | Certification:   | 3 Suicide 6 Could not be determined  | building, etc. (Spec  | ci <b>fy</b> )                                 |   | City or Town,                                    |   |   |
|             | Hosp<br>124 ho<br>16 Fune   | Medical          | 29a. Certifier (Check only one)  1X Certifying Phy 2 Medical Exem  | vsicien: To the best of my kr<br>niner: On the basis of examinated and manner stated.       | nowledge, death occu<br>nation and/or investig | rred at the time, date and place<br>ation, in my opinion, death occu                | e, and due to the cau<br>urred at the time, date | se(s) and manner as<br>and place, and due | stated.<br>to the cause(s)  |
| ł           | To the To the comp  | Ž                | 29b. Signature and title of certifier  | 1-  |  | 29c. License number   | 290  | Date signed (Mont)                        |   |
|             |   |                  | 30. Name and address of person who co  | completed cause of death (fte   |  | - (3/2)   |  |   | - (   |
| 5           | Sta   | te_              | DR. TARIQ MAHMOOD  31. Date filed (Month, Day, Year)   | 2300 DULANE<br>32 Registrar's Sign  | nature   |   | MD 21093   |   |   |
|             | Registr   |                  | DEC 2 7 200  | 5 Been 1  | 4 Back   |   |  |   |   |

State of Maryland / Department of Health and Mental Hygietien () 5 4 165 L 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death **Physician** 8.39 PM BEEMAN DEC LOYCE. 2005 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner BALTIMORE MERCY 1

5. Social Security Number BALTIMORE
If Under 1 Year If Under 24 Hrs. MD MEDICAL CENTER 8. Date of Birth (Month, Day, Yea 4-18-1950 7. Age (In yrs. last birthday) 6. Sex Birthplace (State or Foreign
Country) **Funeral** Months Days Hours 1 ☐ M 2 🖫 F 55 214-56-6012 Director Maryland Usuel Residence of Decedent the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f show other traumatic event, the Madical Examinar must be notified at 1 TyYes 2 ☐ No Director Marvland Baltimore n/a 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 833 W. Pratt Street 21201 United States or Iteme 23a 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give X Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 21 No Specify: ò White 3 Widowed 4 Divorced "natural", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16h. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 72 Depertment of Health and Mental Hygiene. Important: If Iem 27 is marked other then "nateny nijury or other traumatic event, the Malles Once. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Albert Johnson Helen LeDluce 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Melissa Kessler (daughter) 1415 S. Carey St. Baltimore, MD 21230 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XX urial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Glen Haven Mem. Park | 12-23-2005 Glen Burnie, MD 21. Signature of Funeral Service Lincensee McCully-Polyniak Funeral Home, P.A. J. Wayne Osterling 130 E. Fort Ave. Baltimore, MD 21230 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) KLEBSIELLA PNEUMONIA **Physician** /Medical **Examiner** OBSTRUCTIVE PULMONARY DISEASE YEARS MRONIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760 the attending physicien Physician/Medical use as the IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 4 Pregnant at time of death 5 Other (specify) P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ۵ LORONARY ARTERY DISEASE 1 Yes 2 No Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No DIABETES 24a. Was an autopsy performed Yes No 1 ☐ Yes Hospitel or Attending Physician: 25. Was case referred to medical 26. Place of Death | Check only one Hospital: Inpatient examiner Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes V No ၉ 2 ER/Outpatient 3 DOA SIL 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Atter t Natural Injury 5 Pending after death. 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after To the Funerel Direct 4 \ Homicide ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) Z Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D0063326 MD DEC KKWholakia 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KUSH · R. DHOLAKIA MERCY MEDICAL CENTER BALTIMORE, MD (MD) 31. Date filed (Month, Day, Year) State DEC 2 Salva. Registrar

|                   |  |                       | 1 - For<br>State<br>Registrar   |  | State of Maryla   | ind / Departm                                   |   | Ith and M                                      |   | 2005                      | 41655  |
|-------------------|--|-----------------------|---|--|---|---|---|--|---|---------------------------|--|
|                   | Physic<br>/Medi<br>Exami   | cal                   | 1. Decedent's Nam   | MARIE<br>MARIE<br>(If not institution, give  | BRIGHTE   | 31LL  | City, Town, or Loca   |  | 2. Date of Death Month                              | Day Yea  AC. County of De | 5 7:00 AM  |
|                   | Funeral<br>Director  |                       | 785) CF<br>5. Social Security P<br>383 - 63   | -1988 10   | XD. APT. 5<br>x 7. Age (In yrs  | s. last birthday) If U                          | nder 1 Year   If U  | SURN<br>Jnder 24 Hrs.<br>Jours Min.            | 8. Date of Birth<br>(Month, Day, Ye                 | ANNE 9. E                 | ARUNDEL<br>Birthplace (State or Foreign<br>Country)<br>CHIGAN  |
|                   | r 28a-f show   | rector                | Usual Residence of 10a. State  10a. Street and Nu   | 10b. County ANNE A   | IRUNDEL 10c. C  | City, Town or Location                          | BURNI<br>Zip Code   | ΙE   | 10g.  | Citizen of What           | 10d. Inside City Limits 1  Yes 2  Conf   |
| 5-0036            | 2 hours after death with the Marylan<br>atural; or Items 23a or 28a-f show<br>sel Examiner must be notified at   | d by Funeral Director | 11. Marital Status  | RILLEY R   | 12. Was Decedent Ever in Armed Forces?  1   | If Yes,   | ecedent of Hispani<br>specify Cuban, Me<br>es 2 No Spe            | nic Origin? (Spe<br>exican, Puerto l<br>ecity: | U   | VITED                     | STATES merican Indian,   |
| 2121              | 7. ".  | Completed             | Elementary/Seco   | 15. Decedent's Edu<br>cify only highest grad<br>ondary (0-12)<br>(First, Middle, Last) | cation<br>e <i>completed)</i><br>College (1-4or 5+)   | 16a. Decedent's<br>(Give kind of<br>life. DO NO | t work done during<br>T use retired)                              |  | CC  | NVENII                    |  |
| Maryland          | 2 should be filed within and Mental Hygiene. The marked other than reumatic event, the Mental Mental and Menta | To Be                 | BERNI<br>19a. Informant's N   | ARD FL   | EISSNER   |   | E   | LLEN   | (First, Middle, Maid<br>THON<br>I Route Number, Cit | 1PSON                     | , Zip Code)  |
| Baltimore, A      | permit. Pages 1 and 2 should be filed within Deportment of Health and Mental Hygiene. Importants: If Item 27 is marked other than eny injury or other traumatic event, Int. M. ADGE.   |                       |   | position Cremation 3 F 5 Other (Specify)   |   | Place of Disposition cemetery, crematory        | HAMPA<br>(Name of<br>or other place)                              | GNE F  | APT 10 AL<br>2000<br>2005 1-16                      | Location - City of        | RKM 48101<br>or Town, State  |
| Balt              | permit. Pag<br>Depertment<br>Important:<br>eny injury o  |                       | 1 6   | neral Service Licens   |   | ANATON  | e and Address of F  | STRY 750                                       | J CONTESTED E                                       | XQ HANOVIR                | 90016 dm   |
|                   | Physician<br>/Medical  |                       | 23a. Part1. Enter t<br>shock, or hea<br>Immediate Cause<br>disease or condition<br>resulting in death)                                  | (Final   | ications that caused the dealer cause on each line.  Recurr  Due to (or as a conse  | 4. 1  | mode of dying, suc  | 1 0  | r respiratory arrest,                               |                           | Approximate Interval Between Qnset and Death I 8 mm/h 5  |
| 8760,             | cate be executed  whysician and the burial-transit   | ical Examiner         | Sequentially list co<br>if any, leading to in<br>cause. Enter Unde<br>Cause (Disease or<br>that initiated events<br>resulting in death) | erlying<br>injury<br>s   | Due to (or as a consection of the consection of | octable quence of): Octable quence of):         | pai   | n  |   |                           | (mo  |
| P.O. Box 68       | To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours alter death.  To the Funeral Director: Alter this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit   | Physician/Med         | IF FEMALE: 23b. Was deceden in the past 12 1 Yes 2  | Months?  | 3c. If yes, outcome of pregn<br>1 □ Live birth 2 □ Fet<br>4 □ Pregnant at time of<br>9 □ Unknown  | al death 3 Ectop                                | c pregnancy<br>(specify)  |  |   | 23d. Date of d<br>Month   | elivery<br>Day Year  |
| rds, P            | w requires that<br>been signed I<br>should be det  | by                    | Part II. Other signif   | ficant conditions con  | stributing to death but not re  | sulting in the underlyii                        | ng cause given in F   | Part I.  |   | o use contribute          | to the cause of death?   |
| tal Records,      | iician: The law ru<br>certificate has be<br>rector, page 2 sh  | e Completed           | 25. Was case refer  | red to medical   |   |   | 26.5  | Bloom of Double                                | 24a. Was an autopsy performed 1 Yes 2 2 1           | prior to<br>death?        | autopsy findings available completion of cause of s 2 \( \text{No} \)  |
| Division of Vital | kttending Physici<br>death.<br>ctor: After this cer<br>y the funeral direc   | sation: To B          | examiner? 1 Yes 2  27. Manner of Deat 1 Natural 2 Accident  | 5 Pending investigation  | ospital: 1 Inpatient 2 28a. Date of Injury (Month, Day Year)  | 28b. Time of Injury M                           | Other   | Nursing Hom                                    | ne 5 Residence<br>8d. Describe how in               |                           | ecity)   |
| Divi              | To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the   | i Certification:      | 3 Suicide<br>4 Homicide   | 6 Could not be determined  | 28e. Place of Injury - At h<br>building, etc. (Speci  | ify)  |   |  | 8f. Location (Street<br>City or Town, Sta           | ite)                      |  |
|                   | thin 24 ho<br>the Fun<br>the Fun   | Medical               | 29a. Certifier (Check only one)  29b. Signature and   | Z   MOGICAL CXAIIII  | ician: To the best of my knier: On the basis of examination and manner stated.  | ation and/or investiga                          | red at the time, dat<br>tion, in my opinion,<br>29c. License numb | , death occurred                               | d at the time, date a                               | nd place, and du          | e to the cause(s)  |
| ) ,               | 1358   |                       | •   | Mi   | cem D   |   |   |  | 29d. L  | Date signed (Mon          | Control of the contro |
| 3                 | ,  |                       | 30. Name and address  OCL  31. Date filed (Mont   | By J. Le   | mpleted cause of death (Itel<br>26 360   32. Registrar's Sign.  |   | er St.  | Balti  | more m  | D 212                     | 25   |
|                   | Sta<br>Registr   |                       |   | C 2 7 2005   |   | don't   |   |  |   |                           |  |

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrer Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Year December Michael C. Butler 2005 9:00 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** 133 Delaware Avenue Pasadena Anne Arundel 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) JAN 24, 19 Funeral 6. Sex 1 X M 2 ☐ F 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Months Days Hours Min Yrs. Director 226-54-1621 60 Virginia Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show other treumetic event, the Medical Examinar must be notified at 1 ☐ Yes 2X No Director Maryland Pasadena Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Items 23e 133 Delaware Avenue 21122 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 5 No If Yes, Give XX Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 Never Married 2 Married ō Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No þ Specify: 3 ☐ Widowed 4 ☑ Divorced White 'neturef' Completed 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene Importent: If item 27 is marked other then "any righty or other treumetic event, the Magnes. Elementary/Secondary (0-12) College (1-4or 5+) Steel Salesman 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Virginia O'Neil Henry Butler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Justin B. Butler/Son 133 Delaware Avenue Pasadena, MD 21122 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town. State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State \* 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc. 12/23/05 Baltimore, MD 22. Name and Address of Facility Cremation Society of MD, 21. Signature of Funeral Service Licensee 299 Frederick Road Edward A Gregorchik Baltimore, MD 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final Approximate Interval Between Onset and Death **Physician** disease or condition resulting in death) /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): physician Box 68760 Physiclan/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year Month 4 Pregnant at time of death 5 Other (specify) Records, P.O. the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? has autopsy performed? Yes 2 No certificate 1 ☐ Yes 2 ☐ No Division of Vital Yes the Hospital or Attending Physicien: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ▼No 2 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No 2 Accident investigation Director: 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funerel C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Dav. Year) December 22, 2005 se of death (Item 23a) (Type, Print) 32 Registrar's Signature 31. Date filed (Month, Day, Year) State DEC 2 7 Registrar 2005

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene | 5 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** MAE E. BARNES 2005 8:25 AM 12.19 /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death GILCHRIST CENTER BALTIMORE NA If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Months 1 M 2 SF Yrs Director 217.22.1171 11.06.1920 'nc Usual Residence of Decedent 10a. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits 28a-f show traumatic event, the Medical Examinar must be notified at BALTIMORE 1 X Yes 2 No Directo MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6 238 TERR. 4705 GATEWAY APT. 21227 USA or items 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No þ Specify: Specify: BLACK 3 ₩ Widowed 4 Divorced "natural" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry at Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER 6 TH GRADE NA DOMESTIC 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 1 and 2 should be fi Health and Mental Hem 27 Is marked ot RILEY KEVER HEDGEPETH MAGNORA RICHARDSON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 a Department of Health ar Important: If Item 27 Is any injury or othar trau once. 2312 MONTICELLO RD., REGINA BRADBY (NIECE BALTO. MD. Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ■ Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 12.23.05 ARBUTUS BALTIMORE, MD 21. Sign ture of Funeral Service Licensee VAUGHN C. GREENE FUNERAL SERVICE 5151 BALTO NATU PIKE, BALTO MO 21229 Vaughn 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Pancreatic months cancer /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine physician and s the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760. Physician/Medical as attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 prioriths?
1 Yes 2/1 No 9 Unknown 23d. Date of delivery 3 Ectopic pregnancy Day Year 4□Pregnant at time of death 5 ☐ Other (specify) the t 9 Unknown δ signed d be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? certificate has Lirector, page 2 s 24a. Was an autopsy performed? res 2 No 1 ☐ Yes 2 ☐ No 1 Yes Division of Vital o the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one, Other: 4 Nursing Home 5 Residence 6 Nother (Specify NOSPICE Hospital: 1 ☐ Yes 2 No ٤ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death
1 Avatural
2 Accident 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred After I 5 Pending investigation Injury death. 1 Tes 2 No after death 3 ☐ Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a
To the Funeral C Physician: To the best of my knowledge death occurred at the time. It and blace and due to the causa(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) 29b. Signarure and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D58303 December 19 2005 h 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month) Day

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MAE

6601

32. Engistrar's Signature

N. Charles St Towson

ND 21204

CHARLES MD

|            |   |                  | 1 - For State Registrar   | State o            | of Maryla                        |   | artment of I   |                               | ınd Mental Hy                                 | giene                             | )5                        | 416                      | 59          |
|------------|---|------------------|---|--------------------|----------------------------------|---|--|-------------------------------|---|-----------------------------------|---------------------------|--------------------------|-------------|
|            | *   | ē.               | Decedent's Name (First, Middle, La  | st)                |                                  |   |  |                               | 2. Date of D                                  | eath                              |                           | 3. Time o                | of Death    |
|            | Physici<br>/Medi  |                  | Amos F. Blank   |                    |                                  |   |  |                               | Decembe                                       | er 11, 2                          | Year<br>2005              | 3:20                     | AM M        |
|            | Examir  |                  | 4a. Facility Name (If not institution, giv                                    | e street and nu    | mber)                            |   | 4b. City, Town, o  | or Location of                |   |                                   | ty of Death               |                          |             |
| 178        | 76j   |                  | 2141 Hagerstown   | n Lane             |                                  |   | Кеуп   |                               |   |                                   | arrol.                    | 1                        |             |
|            | Funeral   |                  | 5. Social Security Number 6. S  | Sex<br>ISDM 2□F    |                                  | rs. last birthday)                      | If Under 1 Year<br>Months Days                               | If Under 2<br>Hours           | Min. (Month, D                                | rth<br>ay, Year)                  | 9. Birth<br>Cou           | plece (State<br>ntry)    | or Foreign  |
|            | Director  |                  | 180-03-2619 Usuel Residence of Decedent                                       | X                  | 90                               | Yrs.                                    |  |                               | June 2  | 0, 1915                           | Mar                       | yland                    |             |
|            | land  |                  | 10a. State 10b. County  |                    | 10c.                             | City, Town or Lo                        | ocation  |                               |   |                                   |                           | 10d. Inside (            | City Limits |
|            | Mary<br>-fish   | ţō               | MD Carrol   | 1                  |                                  | Kev                                     | mar  |                               |   |                                   |                           | 1 ☐ Yes                  | s 2√∏No     |
|            | n the   | irec             | 10e. Street and Number  |                    |                                  |   | 10f. Zip Code  |                               |   | 10g. Citizen of                   | What Cou                  | ntry?                    |             |
|            | h with  | a D              | 2141 Hagerstown   | Lane               |                                  |   |  | 217                           | 57  | USA                               |                           |                          |             |
|            | filed within 72 hours after death with the Maryland<br>Hygiene.<br>After then "natural", or tlems 23a or 28a-f show<br>ont, tre Medical Exercitive frant by notified at   | Funeral Director | 11. Marital Status  | 12. Was Dec        | edent Ever in                    | U.S. 13.                                | Was Decedent of H  | Hispanic Orig                 | in? (Specify Yes or No<br>Puerto Rican, etc.) | o- 14. Ra                         | ce - Ameri                |                          |             |
| 9          | or It   | y Fu             | 1 ☐ Never Married 2 ☐ Married   | 1 ☐ Yes            | 2 TNo                            |   | 1 ☐ Yes 21 No  | Specify:                      | r derio mican, etc.)                          |                                   | ack, White,               |                          |             |
| 21215-0036 | hours<br>ural',   | d by             | 3 Widowed 4 Divorced  | Year or D          | ates:                            |   |  |                               |   | <i>эрес</i>                       | <sup>⊮y:</sup> whi        | te                       |             |
| 7          | "net  | Completed        | 15. Decedent's E<br>(Specify only highest gra                                 |                    |                                  | (Give                                   | dent's Usual Occup<br>kind of work done<br>DO NOT use retire | during most                   | of working unk                                | 16b. Kind of                      | Business/In               | dustry                   | unk         |
| 12         | withii<br>ene.<br>than  | gmc              | Elementary/Secondary (0-12)   | College (<br>ink   | 1-4or 5+)                        | 1110.                                   | DO NOT USE TELLIE  | u)                            |   |                                   |                           |                          |             |
| 2          | Hygir<br>Hygir<br>Sther   |                  | 17. Father's Name (First, Middle, Last,                                       |                    |                                  |   |  | 18. Mother                    | 's Name (First, Middle                        | , Maiden Suma                     | me)                       |                          |             |
| <u>a</u>   | ould be f<br>Mental I<br>arked of   | To Be            | John C. Blank   |                    |                                  |   |  | Mae                           | Bussard                                       |                                   | ,                         |                          |             |
| Maryland   | 2 should<br>and Men<br>Is marke<br>aumatic  | -                | 19a. Informant's Name/Relationship (  | Type, Print)       |                                  | 19b. Maili                              | ng Address (Street   |                               | or Rural Route Numb                           | er, City or Town                  | n, State, Zip             | Code)                    | unk         |
|            | s 1 and 2 should be filed within 72 hours after death with the Marylan f Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic svent, it a Meulcal Exprisitive traumatic svent, it a Meulcal Exprisitive traumatic. |                  | Carroll Hospice   |                    |                                  |   |  |                               |   |                                   |                           |                          |             |
| altimore,  | es 1 and of Health filtem 27  |                  | 20a. Method of Disposition  | 30 44              |                                  | . Place of Dispo                        | sition (Name of<br>matory or other plan                      | ce)                           | Date  | 20c. Location                     | - City or To              | own, State               |             |
| Ĕ          | Pages<br>nent of<br>ant: If Its<br>ary or o   |                  | 1 ☐ Burial 2 ☐ Cremation 3 ☐ 14 ☐ Donation 5 ☐ Other (Specif                  |                    | State                            | ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, | ,  |                               |   |                                   |                           |                          |             |
| alt        | permit. Pages<br>Department of<br>Important: If It<br>any injury or o   |                  | 21. Signature of Funeral Service Licer<br>Ronal 1 S                           | Wads I             | Directo                          | 22<br>St. St.                           | Name and Addre   | ss of Facility                | pard 655 W.                                   | Roltin                            | noro (                    | Stroot                   |             |
| <u> </u>   | 90 5 5 9  | V A              | 2001001111  | 11 100             |                                  | Ba                                      | altimore,  | MD = 2                        | 21201   |                                   | nore .                    | otieet                   |             |
| De .       |   |                  | 23a. Part1. Enter the disease, or com<br>shock, or heart failure. List only   | pleations that o   | aused the de<br>each line.       | ath. Do not ent                         | er the mode of dyir  | ng, such as c                 | ardiac or respiratory a                       | rrest,                            |                           | Approxima<br>Interval Be | tween       |
| r          | Physician   |                  | Immediate Cause (Final disease or condition                                   | , No               | ns Sr                            | mall (                                  | Ill (  | inc                           | CAN   | er                                |                           | Onset and                | Death       |
| 44         | /Medical<br>Examiner  |                  | resulting in death)   | Due to             | (or as a conse                   | equence of):                            |  |                               | <i></i>                                       |                                   |                           |                          |             |
|            | - Addition  | he               | Sequentially list conditions,   | b. Due to          | <b></b>                          |   |  |                               |   |                                   |                           |                          |             |
|            | bed<br>isit   | Examiner         | if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | Due to             | (or as a conse                   | equence or):                            |  |                               |   |                                   |                           |                          |             |
|            | xecut<br>and<br>al-trar   | xan              | that initiated events resulting in death) Last                                | c.<br>Due to       | or as a conse                    | equence of):                            |  |                               |   |                                   | -                         |                          |             |
| 8760       | The law requires that the death certificate be executed ite has been signed by the attending physician and bage 2 should be detached for use as the burial-transit  |                  |   | _                  | •                                | ,,-                                     |  |                               |   |                                   |                           |                          |             |
| 687        | ficate<br>p physics the   | edicai           |   | . d                |                                  | -                                       |  |                               |   |                                   |                           |                          |             |
| X          | leath certific<br>attending p   | cian/M           | IF FEMALE:<br>23b. Was decedent pregnant                                      | 23c. If yes, out   |                                  |   |  |                               |   | 23d D                             | ate of delive             | erv                      |             |
| ň          | death<br>e atte<br>d for  | Icia             | in the past 12 months?  | 4☐Pregn            | eirth 2 ∏Fe<br>eant at time of   |   | Ectopic pregnancy Other (specify)                            | <i>'</i>                      |   |                                   | onth                      | -                        | Year        |
| 0          | t the<br>by the   | Physi            | 9 Unknown   | 9L Unkn            | own                              |   |  |                               |   |                                   |                           |                          |             |
| _          | res that the de<br>signed by the a<br>be detached to  | by P             | Part II. Other significant conditions of                                      | ontributing to de  | eath but not re                  | esulting in the u                       | nderlying cause giv  | en in Part I.                 | 23e. Did t                                    | obacco use cor                    | tribute to th             | ne cause of o            | jeath?      |
| ğ          | w require<br>been sig<br>should b   | ed               | Wronny 1.   | ren                | use                              | col                                     |  |                               | 1X  | Yes 2□No                          | 3 🗌 Prob                  | ably 4 🗆                 | Jaknown     |
| Records,   | law re<br>as be<br>2 sho  | Completed        | ,   |                    |                                  |   |  |                               | 24a. Was                                      |                                   | Were auto                 | psy findings             | available   |
|            |   | mo:              |   |                    |                                  |   |  |                               | autor<br>perfo                                | ormed?<br>2 No                    | death?                    | mpletion of c            | ause or     |
| Vital      | nysician: Th<br>nis certificate<br>director, pag  | Be (             | 25. Was case referred in medical examiner?                                    |                    |                                  |   |  | 26. Place of                  | of Death (Check only of                       |                                   |                           |                          |             |
| 0          | Physician:<br>r this certific<br>ral director,  | 2                | 1 ☐ Yes 2 ☐ No  | Hospital: 1 □ I    | npatient 2[                      | ☐ ER/Outpatien                          | t 3 DOA Oth  | er: 4 🗆 Nurs                  | sing Home 5 Resi                              | dence 6 🗆 Oti                     | her (Specif               | y)                       |             |
|            | ing P   | on:              | 27. Maprier of Death  1 ☐ Natural 5 ☐ Pending                                 | 28a. Date<br>(Mont | of Injury<br>th, Day Yeer)       | 28b. Time of<br>Injury                  | 28c, Injur<br>Wor  | y at<br>k?                    | 28 Describe                                   | how injury occu                   | rred                      |                          |             |
| <u>s</u>   | death<br>ctor: A<br>y the f   | cati             | 2 Accident investigation 3 Suicide 6 Could not be                             |                    |                                  |   |  | Yes 2□N                       |   |                                   |                           |                          |             |
| Division   | nl or Attending Patter death. I Director: After to in by the funera   | Certification:   | 4 ☐ Homicide determined   | 28e. Place         | of Injury - At<br>ng, etc. (Spec | home, farm, str<br>cify)                | eet, factory, office   |                               | 28f. Location (:<br>City or To                | Street and Num.<br>vn, State)     | ber or Rura               | I Route Num              | ber,        |
|            | To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the fune  |                  | 29a. Certifier Gertifying Ph  | veician: To the    | hact of my le                    | nowledge decit                          | Occurred of the C  | no dete : - '                 | place and division                            |                                   |                           |                          |             |
|            | 24 hd<br>24 hd<br>Fun<br>etely  | edicai           | (Check only 2   Medical Exen  | nner: On the ba    | asis of examir<br>per stated.    | nation and/or inv                       | estigation, in my o  | ne, date and<br>pinion, death | place, and due to the occurred at the time,   | cause(s) and m<br>date and place, | anner as st<br>and due to | ated.<br>the cause(s     | ;)          |
|            | To the within 2 To the complet  | Me               | 29b. Signature and title of certifier   |                    |                                  |   | 29c. Licens  | e number                      | ,   | 29d. Date signe                   | ed (Month,                | Dey, Year)               |             |
|            | ->-0  |                  | 1//   |                    |                                  |   | DC   | 303                           | /   | 2/16                              | 171                       | かて                       |             |
|            |   |                  | 30. Name and address of person who  | completed caus     | e of death (Ite                  | gm 23a) (Type,                          | Print) .   |                               | ,   | 1.0                               |                           | -                        |             |
|            |   |                  | Your of Glashar   | 555 FA             | yth (                            | aster.                                  | Str.0041   | 1 Ker                         | nusta, t                                      | 112011                            | 57                        |                          |             |
|            | Sta   | te               | 31. Date filed (Month, Day Year)  |                    | egistrar's Sigi                  | nature                                  |  |                               | 112000  | 1.30                              |                           |                          |             |
| ¥ 7        | Registr   | ar               | DEC 2 7 20  | JO D               | 18 18 L                          | AS ASS                                  |  |                               |   |                                   |                           |                          |             |

|   | ian   | 1. Decedent's Name (First, Middle, Sylvia   | Last)  | Α.   | Car  | ter-E  | 1  |   |                                  | 2. Date of I   | Day   | y 0.4  | Year  | 3. Time of Dea   |
|---|---|---|--|--|--|--|--|---|----------------------------------|--|---|--|---|--|
| /Medi   |   | 4a. Facility Name (If not institution,  | give street and nu   |  | Cal  | 4b. City, T  |  | Location o                                      | f Death                          | Decen  |   | d3   | ab05  | 210+   |
| Exami   | ier   | Union Memoria   | •  | ,  |  | 40. Oily, 1  |  | timor   |                                  |  | 40.   | County   | NA  |  |
| Funeral   |   |   | 3. Sex   |  | s. last birthday)  |  | Year   | If Under 2                                      | 24 Hrs.                          | 8. Date of B   | lirth   |  |   | ace (State or For  |
| Director  |   | 218-60-5428   | 1□M 2\\ F  | 54   | Yrs.   | Months   | Days   | Hours   | Min.                             | (Month, L  | Day, Year)<br>-1 <b>-</b> 51  | į  | Count   | Md.  |
| >   |   | Usual Residence of Decedent  10a. State 10b. County   |  | 1.0  |  |  |  |   |                                  |  |   |  |   |  |
| show  | ž   |   |  | 10c. C   | City, Town or Lo   | ocation  |  |   |                                  |  |   |  | 10  | d. Inside City Lin   |
| or 28e-f<br>se notifie  | ecto  | Md.   | NA   |  | Balt   | imore  |  |   |                                  |  |   |  |   | XXYes 2  |
| a or  | ä   |   | ******   |  |  | 10f. Zip (   |  | ^   |                                  |  | 10g. Citi   |  | Vhat Count  | ry?  |
| 18 23<br>Turn   | erai  | 3307 Dudley At  | 7enue<br>12. Was Deci  | adent Ever in  | 11.5 12.5  |  | 2121   |   | :-0 (6-                          | -3 \   |   |  | JSA   |  |
| ital hygiene.<br>od other than "natural", or items 23a or 28e-f ahov<br>svent, the Madical Examinar must be notified at   | Funerai Director  | 1 Never Married 2 Married   | Armed Fo   | rces?  | 0.3.   | If Yes, specif   | fy Cubar   | n, Mexican,                                     | , Puerto                         | ecify Yes or N<br>Rican, etc.)   | 10-   |  | e - America<br>k, White, e  |  |
| o'la  | by  | 3 ☐ Widowed 4 ☐ Divorced  | If Yes, Giv<br>Year or D   | /8   |  | 1□Yes 22   | No No  | Specify:  |                                  |  |   | Specify  |   | lack   |
| ical i  | Completed   | 15. Decedent's  | Education  |  |  | dent's Usual   |  |   |                                  |  | 16b. Ki   | nd of Bu   | siness/Indi   |  |
| Man 7.  | npie  | (Specify only highest<br>Elementary/Secondary (0-12)  | College (1   | -4or 5+)   | life.  | kind of work<br>DO NOT use   | done di<br>retired)  | uring most                                      | of worki                         | ng   |   |  |   | ,  |
| e ta  | Con   | 12th Grade  |  | ,  | Env  | ironme   | enta   | l Ser   | vice                             | es   |   | J.H.   | Н.  |  |
| and Mental Hygiene.<br>Is marked other than<br>aumatic svent, the Ma  | Be  | 17. Father's Name (First, Middle, La  | ast)   |  |  |  |  | 18. Mother                                      | 's Name                          | (First, Middl  | e, Maiden   | Sumam  | e)  |  |
| and Mental I<br>s marked or<br>umatic sve   | ဥ   | Jerry   |  |  | Elliso   | n  |  |   | Doro                             | othy   | M   | •  | R   | eid  |
|   |   | 19a. Informant's Name/Relationship  |  |  | 19b. Mailir  | ng Address (   | Street a   | nd Numbei                                       | r or Rura                        | l Route Num  | ber, City o   | r Town,  | State, Zip (  | Code)  |
| of Health and Mer<br>If Item 27 Is marke<br>or other traumatic  |   | Dorothy Peterson  | n Hardy  | Daugh  |  | 310 Fu   | rley   | Aver  |                                  | Balti  |   |  |   |  |
| 0   |   | 20a. Method of Disposition 1   Burial   Burial   Boromation 3   | □ Removal from   | State 20b.   | Place of Dispo   | sition (Name<br>natory or oth  | of<br>er place   | AL 1  |                                  | /05  | 20c. Lo   | cation -   | City or Tow   | vn, State  |
| tent:   |   | 4 Donation 3 ☐ Other (Spe   | icify)   | 4  | reenmou  | int Cer  | m.   | -1<br>-1  | 2 3                              | 3-05-  | Dal   | 1111S  | re, i   | MD.  |
| Department of Importent: If It lend injury or conce.  |   | 21. Signature of Funeral Service Lic  | censee   | 1  |  | . Name and   |  | ,   |                                  |  | timo  |  |   | 21205  |
| D = 0   |   | gagrial   | e co   |  |  | March  |  |   |                                  |  |   | . No   | rth A   | ve.  |
|   |   | 23a. Part1. Enter the disease, or co<br>shock, or heart failure. List on  | omplications that c<br>nly one cause on e                            | aused the dea<br>ach line.   | ath. Do not ent  | er the mode  | of dying   | , such as c                                     | ardiac c                         | r respiratory  | arrest,   |  |   | Approximate<br>nterval Between   |
| ysician   |   | Immediate Cause (Final disease or condition resulting in death)   | G  | TI   | 01   | /  |  |   |                                  |  |   |  |   |  |
| Medical   | ΕI  |   |  |  | Dieen  | (  |  |   |                                  |  |   |  | '   | Onset and Deat   |
| aminer  |   | 1   | Due to (   | or as a conse  | greence of):   | (  |  |   |                                  |  |   | -  |   | Onset and Deat   |
| aminer  | 1   |   | b. C 6   | 10   | Recta  | al C   | Lan  | cer   | ,                                |  |   |  |   | Onset and Deat   |
|   | niner   |   | b. C 6   | or as a conse  | Recta  | al C   | Lan  | cer   | ·                                |  |   |  |   | Onset and Deat   |
|   | xaminer   | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  | b  | or as a conse  | Recta  | al C   | Lan  | cer   | ,                                |  |   |  |   | Onset and Deat   |
|   | ai Examiner   | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events   | b  | 10   | Recta  | al C   | Lan  | icer  | ,                                |  |   |  |   | Onset and Deat   |
| hysician and<br>the burial-transit  | dicai   | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events   | b  | or as a conse  | Recta  | al C   | Lan  | icer  | ,                                |  |   |  |   | Onset and Deat   |
| hysician and<br>the burial-transit  | dicai   | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  | b  | or as a conse  | Recta  | al C   | Lan  | icer  | ,                                |  |   |  |   |  |
| attending physician and<br>for use as the burial-transit  | dicai   | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (bisease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  | b. Due to ( c. Due to ( d  | or as a conse  | Rectarduence of):  | a / C  | gnancy   | cer   | ,                                |  | 2   | 3d. Date   | of delivery   | ,  |
| attending physician and<br>for use as the burial-transit  | dicai   | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant   | b. Due to ( c. Due to ( d  | or as a conse  | Rectarduence of):  | Ectopic preg   | gnancy   | icer  | ,                                |  | 2   |  | of delivery   | ,  |
| ed by the attending physician and detached for use as the burial-transit  | Physician/Medicai   | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (bisease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1  Yes 2 MNo 9 Unknown                                      | b. Due to (  c. Due to (  d  | or as a conse  | Rectardumence of):   | Other (spec  | gnancy   |   | ,                                | 23e. Did   |   | Mon  | e of delivery   | /<br>Pay Year  |
| gned by the attending physician and be detached for use as the burial-transit   | by Physician/Medicai  | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 \( \text{Yes} \) 2 \( \text{No} \)                         | b. Due to (  c. Due to (  d  | or as a conse  | Rectardumence of):   | Other (spec  | gnancy   |   |                                  |  | tobacco us  | Mon<br>se contri   | e of delivery   | yay Year   |
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| ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit  | Completed by Physician/Medical                              | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (bisease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown  Part II. Other significant conditions | b. Due to (  c. Due to (  d  | or as a conse  | Rectardumence of):   | Other (spec  | gnancy<br>iffy)<br>use given   | in Part I.                                      |                                  | 24a. Was<br>auto<br>perf<br>1 Yes  | Yes 2 [ s an psy ormed? 2 No  | Mon<br>se contri   | e of delivery th D bute to the 3 Probat /ere autops rior to compath?  | cause of death   |
| certificate has been signed by the attending physician and rector, page 2 should be detached for use as the burial-transit  | Be Completed by Physician/Medical                           | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (bisease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes   | b. Due to ( c. Due to ( d. 23c. If yes, out 1 Live b 4 Pregn 9 Unkno | or as a conse  | Rectardum Rectar | Other (spec  | gnancy<br>ify)<br>ise giver  | in Part I.                                      | of Death                         | 24a. Was<br>auto<br>perf<br>1 Yes  | Yes 2 San poy ormed? 2 No one)  | Mon<br>se contri   | bute to the 3 Probat for a utops for for compath? Yes 2               | cause of death   |
| is certificate has been signed by the attending physician and director, page 2 should be detached for use as the burial-transit   | To Be Completed by Physician/Medical                        | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  | b. Due to ( c. Due to ( d  | or as a consection or as a consection of pregrent 2 Fet and at time of what who are the but not respectively.  | Rectarday  | Other (spec  | gnancy<br>iffy)<br>use giver   | in Part I.<br>26. Place c<br>4 □ Nurs           | of Death                         | 24a. Waa auto perfi 1 Yes  (Check only ne 5 Res  | tobacco us<br>Yes 2 [<br>s an opsy<br>ormed?<br>2 No one)                                       | Mon se contri No 24b. W pr de                                | bute to the 3 Probat  | cause of death   |
| is certificate has been signed by the attending physician and director, page 2 should be detached for use as the burial-transit   | To Be Completed by Physician/Medical                        | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  | b  | or as a conse  | Rectardum Rectar | Other (spec  | Other  | in Part I.<br>26. Place of<br>4 □ Nurs          | of Death                         | 24a. Was<br>auto<br>perf<br>1 Yes  | tobacco us<br>Yes 2 [<br>s an opsy<br>ormed?<br>2 No one)                                       | Mon se contri No 24b. W pr de                                | bute to the 3 Probat  | cause of death   |
| is certificate has been signed by the attending physician and director, page 2 should be detached for use as the burial-transit   | To Be Completed by Physician/Medical                        | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  | b  | or as a consector as  | equence of):  eq | Other (special deriving cause of the state o | gnancy cify)  Other Cificular Section 1 1 Yes                                  | in Part I.<br>26. Place c<br>4 □ Nurs           | of Death<br>sing Hon<br>2        | 24a. Was autoperf 1 Yes  (Check only ne 5 Res  | tobacco us<br>Yes 2 [<br>s an<br>pry<br>pry<br>ormed?<br>2 No<br>one)<br>idence 6<br>how injury | Mon  se contri  No  24b. W pr de 1                           | bute to the 3 Probat /ere autops/ior to compath? Yes 2                | cause of death   |
| rise usean.  Sirestor, After this certificate has been signed by the attending physician and in by the funeral director, page 2 should be detached for use as the burial-transit. | To Be Completed by Physician/Medical                        | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  | b  | or as a consector as  | equence of):  eq | Other (special deriving cause of the state o | gnancy cify)  Other Cificular Section 1 1 Yes                                  | in Part I.<br>26. Place of<br>4 □ Nurs          | of Death<br>sing Hon<br>2        | 24a. Wa auto perf 1 Yes  (Check only ne 5 Res 8d. Describe   | tobacco us<br>Yes 2 [<br>s an<br>pry<br>pry<br>ormed?<br>2 No<br>one)<br>idence 6<br>how injury | Mon  se contri  No  24b. W pr de 1                           | bute to the 3 Probat /ere autops/ior to compath? Yes 2                | cause of death<br>oly 4 Unknows<br>of findings availabletion of cause  |
| instructure.  The regard.  The continue has been signed by the attending physician and in by the funeral director, page 2 should be detached for use as the burial-transit.       | ai Certification: To Be Compieted by Physician/Medicai      | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that inflated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   | b  | or as a consection or as a consection of pregree of pregree and at time of two at the but not respect to the patient 2 [Injury of Injury - At high etc. (Special post of my kn.)   | properties of the properties o | Other (special deriving cau and a special derivi | Other  | 26. Place of 4 Nursattes 2 No                   | of Death                         | 24a. War auto perf 1 Yes  (Check only ne 5 Res 8d. Describe  8f. Location City or To   | Yes 2 san psy ormed? 2 No one) idence 6 how injury  | Mon se contri No 24b. W pr de 11                             | bute to the 3 Probat /ere autops/ror to commath? Pres 2 r (Specify)   | cause of death on the cause of death of cause of death of cause of the |
| rise usean.  Sirestor, After this certificate has been signed by the attending physician and in by the funeral director, page 2 should be detached for use as the burial-transit. | ai Certification: To Be Compieted by Physician/Medicai      | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that inflated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   | b  | or as a conse  or as a conse  or as a conse  come of pregrirth 2   Fet ant at time of win  ath but not re  inpatient 2    finjury h, Day Year)  of Injury - Ath g, etc. (Specia  | properties of the properties o | Other (special deriving cau and a special derivi | Other  | 26. Place of 4 Nursattes 2 No                   | of Death                         | 24a. War auto perf 1 Yes  (Check only ne 5 Res 8d. Describe  8f. Location City or To   | Yes 2 san psy ormed? 2 No one) idence 6 how injury  | Mon se contri No 24b. W pr de 11                             | bute to the 3 Probat /ere autops/ror to commath? Pres 2 r (Specify)   | cause of death?  cause of death?  Oly 4 Unknown  y findings availabletion of cause  No  Route Number,  |
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| is certificate has been signed by the attending physician and director, page 2 should be detached for use as the burial-transit   | edical Certification: To Be Completed by Physician/Medical  | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  | b  | or as a consector as  | properties of the properties o | derlying cau  and DOA  bet, factory, coccurred at estigation, in   | gnancy iffy)  See given  Other Injury a Work?  1 Ye office  the time a my opin | 26. Place of 4 Nursat at and nion, death number | of Death sing Hon 2 o 2 place, a | 24a. War auto performed for the control of the cont | Yes 2 san psy ormed? 2 No one) idence 6 how injury  (Street and wm, State)  cause(s) a date and | Mon  Se contri  No  24b. W pr de 11  Other occurre  I Number | bute to the 3 Probat /ere autops/ior to compath? Yes 2 r (Specify) id | cause of death only 4 Unknown of the cause of death only 4 Unknown of the cause of  |
| rise usean.  Sirestor, After this certificate has been signed by the attending physician and in by the funeral director, page 2 should be detached for use as the burial-transit. | Medical Certification: To Be Completed by Physician/Medical | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  | b. Due to ( c. Due to ( d  | or as a consection or as a consection of pregrent 2 Fet and at time of what who is at the but not respectively, Day Year) of Injury - At high etc. (Special Special Sp | equence of):  eq | derlying cau  a 3 DOA  28c  M  eet, factory, c  occurred at estigation, in   | gnancy iffy)  See given  Other Injury a Work?  1 Ye office  the time a my opin | 26. Place of 4 Nurs at as 2 No                  | of Death sing Hon 2 o 2 place, a | 24a. War auto performed for the control of the cont | Yes 2 san psy ormed? 2 No one) idence 6 how injury  (Street and wm, State)  cause(s) a date and | Mon  Se contri  No  24b. W pr de 11  Other occurre  I Number | bute to the 3 Probat /ere autops/ior to compath? Yes 2 r (Specify) id | cause of death only 4 Unknown of the cause of death only 4 Unknown of the cause of  |

|              |   |                | For   | State  | of Maryla  | •                                  |                                  |                                |                                | lental Hyg                                | giene                            | 15                        | 11661  |
|--------------|---|----------------|---|--|--|------------------------------------|----------------------------------|--------------------------------|--------------------------------|---|----------------------------------|---------------------------|--|
|              |   |                | Registrar   |  |  | Ce                                 | rtificate                        | of Dea                         | atn                            | 2 Date of Dea                             | leg. No.                         | / U                       | 2 Time of Dooth                                    |
|              | Physicia  | an             | 1. Decedent's Name (First, Middle ROy E.  | e, Lasi)<br>Case                                 | Sr.  |                                    |                                  |                                |                                | Decembe                                   | Dav                              | Ž005                      | 3. Time of Death 9:35 P M                          |
|              | /Medic  |                | 4a. Facility Name (If not institutio  |  |  |                                    | 4b. City, To                     | own, or Local                  | tion of Death                  | Весенье                                   | 4c. Count                        |                           | 3.33 1   |
|              | Examin  | er             | Chesapeake Ho   | -  |  |                                    |                                  | Linth                          |                                |   |                                  | Arun                      | del  |
| P            | Funeral   |                | 5. Social Security Number   | 6. Sex   | 7. Age (In yrs                                   | s. last birthday)                  | If Under 1                       | Year If U                      | nder 24 Hrs.<br>urs Min.       | 8. Date of Birth<br>(Month, Day<br>Jan. 2 | Year)                            | 9. Birthp                 | lace (State or Foreign                             |
|              | Director  |                | 216-42-3926   | 1X M 2□F   | <u> </u>   | 63 Yrs.                            |                                  |                                |                                | Jan. 2                                    | 7 1942                           |                           | MD   |
|              | and w   |                | Usual Residence of Decedent  10a, State 10b, County   |  | 10c. C   | City, Town or Lo                   | ocation                          |                                |                                |   |                                  | 1                         | Od. Inside City Limits                             |
|              | f sho   | ō              | Maryland Anne   | Arundel  |  |                                    | Br                               | rook]v                         | n Park                         |   |                                  |                           | 1 ☐ Yes 2 🖾 No                                     |
|              | the rout  | Directo        | 10e. Street and Number  | 711 diluci                                       |  |                                    | 10f. Zip C                       |                                |                                |   | 10g. Citizen of                  | What Coun                 | itry?  |
|              | within 72 hours after death with the Maryland<br>ene.<br>Itan "natural", or iteme 23a or 28a-f show<br>Ita Medical Examiner must be notitled at                   | D              | 201 West Rive   | rview Roa  | ıd   |                                    |                                  | 21                             | 225                            |   |                                  | USA                       |  |
|              | eme a   | Funeral        | 11. Marital Status  | Armed  | cedent Ever in<br>Forces?                        | U.S. 13.                           | Was Deceder                      | nt of Hispani<br>y Cuban, Me   | c Origin? (Sp<br>xican, Puerto | ecify Yes or No-<br>Rican, etc.)          | 14. Ra                           | ce - Americ               |  |
| ð            | or it   | by Fu          | 1 Never Married 2 Mar   | If Yes (   | s 2∏XNo<br>Give                                  |                                    | 1 Yes 2                          |                                |                                |   | Specia                           |                           | nite   |
| Ş            | hours<br>tural  | d be           | 3 Widowed 4 Divorced  | Year or  | Dates:   | 16a Dece                           | dent's Usual (                   | Occupation                     |                                |   | 16b. Kind of B                   | lusiness/Inc              | dustry   |
| Ċ            | in 72<br>in 72<br>in a  | olete          | (Specify only highe   | st grade completed                               |  | (Give                              | kind of work<br>DO NOT use       | done during<br>retired)        | most of work                   | ing                                       | TOD: THING OF E                  | , 10 000 1110             | ,  |
| 9500-61212   | y with  | Completed      | Elementary/Secondary (0-12)   | College  | (1-4or 5+)                                       | 1                                  | Public                           | Works                          |                                |   | County                           | Gove                      | rnment   |
|              | be filed within 72 hours after death with the Marylan Hygiene. d other than "natural", or iteme 23a or 28a-f show event, the Madical Examinar must be notified at | BeC            | 17. Father's Name (First, Middle,   |  |  |                                    |                                  |                                |                                | e (First, Middle,                         |                                  | me)                       |  |
| <u>X</u>     |   | To             |   | se   |  |                                    |                                  |                                | lanche                         |   | parks                            |                           |  |
| Maryland     | s 1 and 2 should<br>f Health and Mer<br>item 27 is marke<br>other traumatic   |                | Janet L. Case   | ship <i>(Typ</i> e, <i>Print)</i><br>(SDOL       | use)   |                                    |                                  |                                |                                | al Route Numbe<br>ad, Bro                 |                                  |                           | MD 21225   |
| စ်           | s 1 ar<br>f Hea<br>item other   |                | 20a. Method of Disposition  |  | 20b.   | Place of Dispo                     | osition (Name                    | er place)                      |                                | Date                                      | 20c. Location                    | - City or To              | wn, State  |
| Ē            | Pages<br>iment of<br>tant: If it<br>jury or o   |                | 1 🖾 Burial 2 □ Cremation<br>4 □ Donation 5 □ Other (\$  |  |  | en Hav                             |                                  |                                | Dec.                           | 005                                       | Glen Bu                          | rnie,                     | Maryland   |
| Baltimore,   | permit. Page<br>Department (<br>Important: If<br>any injury or<br>once.   |                | 21. Signature of Funeral Service  | Ligensee   |  | 2:                                 | 2. Name and                      |                                |                                |   |                                  |                           | ome. P.A.  |
| n            | 80 E ≥ 9  |                | bhod  | XX   |  |                                    |                                  |                                |                                | d, Pasa                                   |                                  | D 211                     |  |
|              | W 1   |                | 23a. Part1. Enter the disease, o shock, or heart failure. Lis   | r complications that<br>t only one cause or      | each line.                                       | ath. Do not en                     |                                  |                                |                                |   | est,                             |                           | Approximate<br>Interval Between<br>Onset and Death |
|              | Physician   |                | Immediate Cause (Final \ disease or condition resulting in death)   | a  | 12 La  | late                               | B) 0                             | delo                           | ~ C                            | erca                                      |                                  |                           | lyear  |
|              | /Medical<br>Examiner  |                | rodaling in additing  | Due t  | o (or as a conse                                 | equence of):                       | 0 (                              | 20 0                           | _                              | erce-                                     |                                  |                           | 2  |
|              |   | ег             | Sequentially list conditions, if any, leading to immediate  | b. Due t   | o (or as a conse                                 | equence of):                       | vaa                              | an                             | -0-0                           |   |                                  |                           | 24,5   |
|              | d<br>d<br>ansit   | Examiner       | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events | <b>S</b> .                                       |  |                                    |                                  |                                |                                |   |                                  |                           |  |
| Š,           | be executed<br>sicien and<br>burial-transit   |                | resulting in death) Last  | Due t  | o (or as a conse                                 | equence of);                       |                                  |                                |                                |   |                                  |                           |  |
| 68/60        | # % @   | dical          |   | d  |  |                                    |                                  |                                |                                | · · · · · · · · · · · · · · · · · · ·     |                                  |                           |  |
|              | eath certificat<br>attending phy<br>for use as the  | Physician/Med  | IF FEMALE:  | 23c. If yes, o                                   | outcome of preg                                  | nancy                              |                                  |                                |                                |   | 23d Da                           | ate of delive             | N/V  |
| ROX          | atten<br>for u  | clan           | 23b. Was decedent pregnant<br>in the past 12 months?<br>1 ☐ Yes 2 ☐ No  | 1 Live   | a birth 2 ☐ Fe<br>gnant at time of               | tal death 3                        | ∃Ectopic preg<br>∃ Other (spec   |                                |                                |   |                                  |                           | Day Year   |
| oj.          | that the de   | hysi           | 9 Unknown   | 9□Unl  | rnown  |                                    |                                  |                                |                                |   |                                  |                           |  |
| ري<br>ح      | es tha<br>igned I<br>be det   | by P           | Part II. Other significant conditi  | ons contributing to                              | death but not re                                 | esulting in the u                  | inderlying cau                   | use given in F                 | Part I.                        | 23e. Did to                               |                                  |                           | ne cause of death?                                 |
| ğ            | w require<br>been sign  |                |   |  |  |                                    |                                  |                                |                                | 1 🗆 Y                                     | es 2 No                          | 3 Prob                    | ably 4 Unknown                                     |
| Hecords,     | The law requires that the death certifica<br>te has been signed by the atlending ph<br>age 2 should be detached for use as it                                     | Completed      |   |  |  |                                    |                                  |                                |                                | 24a. Was a autop:                         | sy                               | prior to cor              | psy findings available<br>npletion of cause of     |
| I<br>F       |   |                |   |  |  |                                    |                                  |                                |                                | perfor                                    | 21 <b>X</b> No                   | death?                    | 200 No   |
| Vital        | Physician: Th<br>this certificate<br>ral director, pag  | Be             | 25. Was case referred to medica examiner?   | Hospital:  | The street of                                    | 7.68/0                             |                                  | Othor                          |                                | h (Check only or                          |                                  | CV67                      | node Horrice                                       |
| ö            |   | To It          | 1 Tyes 2 No   | 28a. Dat   | e of Injury                                      | 28b. Time o                        |                                  | c. Injury at<br>Work?          | Nursing Ho                     | me 5 Resid                                |                                  |                           | 1 Moust  |
| 0            | Attending For death.  | atior          | 1 Natural 5 Pendi<br>2 Accident invest  | ng (Mo<br>igation                                | onth, Day Year)                                  | Injury                             | м                                | Work?<br>1 ☐ Yes               | 2 🗆 No                         |   |                                  |                           |  |
| Division     | or Attendi<br>after death.<br>Director: A<br>in by the fu   | Certification; | 3 Suicide 6 Could 4 Homicide deterr   | nined   208. Fld                                 | ce of Injury - At<br>Iding, etc. (Spec           | home, farm, st                     | reet, factory, o                 | office                         |                                | 28f. Location (S<br>City or Tow           |                                  | ber or Rura               | l Route Number,                                    |
| $\bar{\Box}$ | ital o<br>urs aft<br>rai Di   |                |   |  |  |                                    |                                  |                                |                                |   |                                  |                           |  |
|              | To the Hospital or At within 24 hours after or To the Funeral Directompletely filled in by  | edical         | 29a. Certifier Certifyi (Check only 2 Medical one)  | ng Physician: To t<br>Examiner: On the<br>and ma | he best of my ki<br>basis of examinanner stated. | nowledge, deat<br>nation and/or in | h occurred at<br>vestigation, in | t the time, da<br>n my opinion | te and place,<br>, death occur | and due to the c<br>red at the time, c    | ause(s) and m<br>late and place, | anner as st<br>and due to | ated.<br>the cause(s)                              |
|              | To the<br>within<br>To the<br>compl   | Me             | 29b. Signature and little of certific   | र्ग  | -17  | /                                  | 29c. I                           | License num                    |                                |   | 9d. Date signe                   |                           |  |
|              | . (   |                | 1 fr  | June   | The  |                                    |                                  | 1/51                           | 11/                            | 14, G/                                    | Keen                             | 6416                      | 7,2005   |
|              | X   |                | 30. Name and address of person  | who completed ca                                 | use of death (fa                                 | em 23a) (Type,                     | Print)                           | 2 50.1                         | 100                            | W. G./                                    | enBu                             | 204                       | 11/10/1  |
| <b>6</b>     | Sta   | te             | 31. Date filed (Month, Day, Year  | ) 82   | Registrar's Sig                                  | nature                             | 1 /76                            | 161.7                          | w/ DI                          | 7   | 1)29                             | 2071                      | " CIULA  |
|              | Registr   |                | DEC 2 7 2   | 105  | he di  | Moon                               | K                                |                                |                                |   |                                  |                           |  |

State of Maryland / Department of Health and Mental Hygiene 1 - For Stata Registrer Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death  $1^{\frac{Month}{2}}$ 18 2005 **Physician** 03:16 AM Marcellus Robert Chichester /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Prince George's Park Tokama Washington Adventist Hospital

5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. 8. Date of Birth (Month, Day, 06 25 Birthplace (State or Foreign Country)
\_\_\_\_\_ **Funeral** 1**√2** M 2□ F DC 1922 578-20-8611 83 Director Usual Residence of Decedent 10d. Inside City Limits death with the Maryland 10c. City, Town or Location 10a. State 10b County If item 27 is marked other then "natural", or items 23a or 28a-f show or other traumatic event, the Mactical Examiner must be notified at 1 DYes 2 □ No DC Washington Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20001 USA #507 401 K Street N.W. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No if Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 11 Marital Status filed within 72 hours after 1 XNever Married 2 ☐ Married Specify: Black Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 2 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. int: If itam 27 is marked other than " Elementary/Secondary (0-12) College (1-4or 5+) Army Topographer US Government 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Chester Rudolph Chichester Teressa Maudine Coates 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) #11 R Street N.E. #401 Washington, DC 20002 Sheila Link - Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State permit. Page Department o important: If any injury or once. Riverdale Crematory 12-27-05 Riverdale, MD \* 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licenses 3831 Ga., Ave NW 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. DC 20011 Wash., Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner 10 mic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23h Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 5 Other (specify) 4 Pregnant at time of death the shed for I ☐ Yes 2 ☐ No 9 Unknown 9 Unknown been signed by t should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part Š 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has le 2 autopsy performe 1 Tyes certificate le e 27 To the Hospital or Attending Physician: within 24 hours after death.

To tha Funaral Diractor: After this certifica 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home Hospital: 1 □ Yes 2 No 1 patient 3□ DOA 5 ☐ Residence 6 ☐ Other (Specify) ို 2 ER/Outpatient After thi Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NIW WASH. SUITE RVIA Day, Year) 32. Registrar's Signature 31. Date filed State Registrar

|             |  |                           | For<br>State<br>Registrer   | State of M   | aryland       |                              |  | of Health a<br>of Death             |               |  | jiene<br>0                      | 5 4                         | 1663   |
|-------------|--|---------------------------|---|--|---------------|------------------------------|--|-------------------------------------|---------------|--|---------------------------------|-----------------------------|--|
| Û           | Physici<br>/Medic  |                           | Decedent's Name (First, Midd  | Richard  | V             | V. Cha                       | ıse  |                                     |               | 2. Date of Dea<br>Month<br>12            | Day                             | Year<br>2005                | 3. Time of Death  10:18 p M                      |
|             | Examin   |                           | 4a. Facility Name (If not institution 5505 Sewar  | d Avenue   |               |                              | Ba1  |                                     |               |  |                                 | N/A                         |  |
|             | Funeral<br>Director  |                           | 5. Social Security Number 213-52-0846 Usual Residence of Decedent   | 6. Sex<br>1 M 2 □ F  | 6 (In yrs. Ia | st birthday)<br>Yrs.         | If Under 1 Y<br>Months Da                        | ear If Under<br>ays Hours           | Min.          | 8. Date of Birth<br>(Month, Day<br>9-25- | Year)                           | 9. Birthp<br>Coun           | place (State or Foreign<br>htry)  Md             |
|             | a-f show   | ctor                      | 10a. State 10b. Count   | N/A  |               | Town or Lo                   |  |                                     |               | -  |                                 | 1                           | 0d. Inside City Limits 1X Yes 2 □ No             |
|             | with the   | i Dire                    | 10e. Street and Number 5505 Seward  | Ävenue   |               |                              | 10f. Zip Co                                      | <sup>de</sup><br>1206               |               | 1  | USA                             |                             | itry?  |
| 036         | permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hygiene. Depertment of Health and Mental Hygiene Important: if Item 27 is marked other than "natural", or Items 23a or 28a-f show any fujury or other traumatic event, the Medical Exemplar must be natilised at ODGE. | by Funeral Director       | 11. Marital Status  1 Never Married 2 Ma 3 Widowed 4 Divorce  | 12. Was Decedent Armed Forces?   |               |                              |  | of Hispanic Or<br>Cuban, Mexical    |               | city Yes or No-<br>lican, etc.)          | 14. Ra                          | ice - Americ<br>ack, White, |  |
| 21215-0036  | within 72 ho<br>ene.<br>than "natur<br>ne Madical  | Completed                 |   |  | 5+)<br>N/A    | (Give                        | dent's Usual O<br>kind of work d<br>DO NOT use n | lone during mos<br>etired)          | st of working | g  | Hauss<br>Resta                  | er                          | rysut  |
| Maryland 2  | uid be filed<br>Mental Hygi<br>arked other<br>atic event, I  | To Be Co                  | 17. Father's Name (First, Middle<br>Richard A. Cha  | , Last)  |               |                              | 1  | 18. Mothe                           | e M.          | (First, Middle,<br>Hall                  |                                 |                             |  |
| Man         | id 2 sho<br>lth and<br>27 is ma<br>trauma  |                           | 19a. Informant's Name/Relation Shirley M. Cha   |  |               | 200                          |  | rd Aveni                            |               |  |                                 |                             | Code)  |
| Baltimore,  | Pages 1 an<br>nent of Hee<br>ant: If item 3<br>ary or other  |                           | 20a. Method of Disposition  X Burial 2 Cremation 4 Donation 5 Other (   | 3 □Removal from State  | cer           | nce of Dispo<br>metery, crer | natory or other                                  | of                                  | Da            |  | 20c. Location                   | - City or To                |  |
| Balt        | permit. Depertrimports any inje  |                           | 21. Signature in Funeral Service  | r C. Duy   | nt            |                              |  | ddress of Facili                    | O Wal         | bash Av                                  | enue                            |                             | , Md 21215                                       |
|             | Physician<br>/Medical<br>Examiner  | Examiner                  | 3a. P. (1. Enter the disease, c sock, or heart failure. Lis Imm diate Cause (Final disease or condition regulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying | a  | a conseque    | ance of):                    | er the mode of                                   | YC/M                                | M/D           | respiratory arr                          | 14119                           | 1                           | Approximate Interval Between Oncet and Deall     |
| Box 68760,  | death certificate be executed<br>e attending physicien end<br>od for use as the burial-transit   | by Physician/Medical Exar | that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  | c. Due to (or as d   | of pregnand   | cy                           | Ectopic pregn                                    |                                     |               |  |                                 | ate of delive               | ory<br>Day Year                                  |
| P.O. I      | 0 0 0  | Physic                    | 1 Yes 2 No<br>9 Unknown   | 4 □ Pregnant at<br>9 □ Unknown   |               |                              | Other (specif                                    |                                     |               | 220 Did to                               |                                 |                             | ne cause of death?                               |
| ords,       | The law requires that the site has been signed by the bage 2 should be detache   |                           | Part II. Other significant condit   | Toris community to death b   |               | ung ar tire u                | indenying caus                                   | - given in Fait                     |               |  | es 2 No                         | 3 Prob                      |  |
| al Record   |  | Completed                 |   | ,  |               |                              |  |                                     |               |  | med?<br>22/2 No                 | prior to cor<br>death?      | psy findings available mpletion of cause of 2 No |
| Vital       | Physician:<br>rthis certificant al director.   | To Be                     | 25. Was case referred to medical examiner? 1 ☐ Yes 2 € No   | Hospital:  | ent 2 E       | R/Outpatier                  | it 3□ DOA  | Othor                               |               | Check only on                            |                                 | her (Specify                | y)   |
| Division of | To the Hospital or Attending Ph<br>within 24 hours efter death.<br>To the Funeral Director: After th<br>completely filled in by the funeral  | Certification: 7          | 3 Suicide 6 □ Could   | tigation   |               | 28b. Time of<br>Injury       | М  | Injury at Work?                     | No            | 3d. Describe ho                          |                                 |                             | il Route Number,                                 |
| Div         | itel or A  |                           | 4 Homicide determined   | building, et   | c. (Specify)  |                              |  |                                     |               | City or Town                             | n, State)                       |                             |  |
|             | To the Hospitel or within 24 hours efter To the Funerel Dir completely filled in   | edicai                    | 29a. Certifier 1 Certifyi (Check only 2 Medica one)   | ing Physicien: To the best<br>Il Examiner: On the basis o<br>and manner st | f examination | ledge, death<br>on and/or in | occurred at the vestigation, in a                | he time, date an<br>my opinion, dea | id place, an  | nd due to the cad at the time, d         | ause(s) and m<br>ate and place, | anner as st<br>, and due to | ated.<br>the cause(s)                            |
| )           | To t<br>To t   | Σ                         | 29b. Signature and title of certific  | 1/ Palmer  | M             | 7                            | 29c. Lie   | cense number                        | 1             | 2  | 9d. Date signe                  | 22/                         | 0 dy, Year)                                      |
|             | 7  |                           | 30. Nave and address of a sor   | n who complete cause of d  | leath (Item   | (За) (Туре,                  | Print)   | 1 AN                                | 1             | BUHI                                     | MOVA                            | M                           | 121218   |
| 49          | Sta<br>Registr   | -                         | 31. Date filed (Month, Day, Year DEC 2 7  | 200  | ar's Signatu  | ire                          | K.   | - uj                                |               | <i>S</i>                                 |                                 | , , , , , ,                 |  |

State of Maryland / Department of Health and Mental Hygiene 05 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Month **Physician** Joseph L. Carter December 23 2005 10:00a /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** 7504 Patapsco Drive Sykesville Carroll If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Feb 10 Birthplace (State or Foreign County) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months 1**X** M 2□ F 81 219-16-5582 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: if lem 27 is marked other than "natural" or its marked or its 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Sykesville Director Carroll 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21784 USA 7504 Patapsco Drive Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: White Specify Completed by If Yes, Give Year or Dates: 3 ☐ Widowed 4 ☐ Divorced WWII 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Stationery Engineer Engineering 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Gladys Harrison Lyal Carter 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Catherine A. Carter (Spouse) 7504 Patapsco Drive Sykesville, MD 21784 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) 12/26/2005 Sykesville, MD All County Cremation 21. Signature of Funeral Service Licensee AATGAT AGASEKAL HOME & CHAPEL, PA (B Sykesville, AD 21784 (410) 795-1400 (Box 195) suun a. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) FIBRILLATION VENTRICULAR Physician Curkuy /Medical Due to (or as a consequence of): **Examiner** CARDIOVASCULAR DISTASE HTHE ROSCLERGTIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, the attending physician Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4 Pregnant at time of death 5 Other (specify) detached 9 Unknown been signed by the should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 \( \subseteq \text{ Yes} \) 2 \( \subseteq \text{ No} \) 24a. Was an page 2 certificete has autopsy performed 20 1 Yes Hospitel or Attending Physicien: Be 25. Was case referred to medical examiner? director 26. Place of Death (Check only one, Hospital: 1 | Inpatient Other: 4 Nursing Home 5 Presidence 6 Other (Specify) 2 No Certification: To 1 🗌 Yes 2 ER/Outpatient 3□ DOA After this funeral Manne of Death 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1 Natural Injury 1 TYes 2 No investigation 2 Accident within 24 hours after deatl To the Funerel Director: 6 Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 29a. Certifier 1 🕑 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number Colinacted Nat DO018200 12123/05 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 100 - A POOLE (Ld. WESTMINSTER MD 21157 100-A POOLE 31. Date filed (Month, Day, Year) 32\_Registrar's Signature State Registrar

**ORIGINAL** 

Amend item#1, period 351, 1/10 to 11

Amend item#1, period 351, 1/10 to 11

State of Maryland / Department of Health and Mental Hygiene 15 1 - State Registrar Certificate of Death Rag. No. 3. Time of Death McKeever Edward Conwell 2. Date of Death 1. Decedent's Name (First, Middle, Last) CONWELL 05/7 **Physician** MCKEEVER 20, 2005 Jecember /Medical 4b. City own, or Location of Death Examiner Himore ente TOWN or Foreign last birthday) Number **Funeral** 528 Days Hours 2 🗆 F Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. Cir Town or Location 10a. State the Medical Examiner must be notified at 1 ☐ Yes 2 No Director 28e-f 10g. Citizen of What Country? 10e. Street and Number ISA ŏ or items 23a Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? ↑ Yes 2 □ No I¥Yes, Give Year or Dates: 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: 3 Widowed 4 Divorced "naturel", 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) most of working Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) durs and Mental Hygid other traumatic event. 18. Mother's Name (First) Middle Maiden Sumame) Name (First, Middle, Last) Father's Be Pages 1 and 2 should be 2 Informant's Name/Relationship (Type 21133 item 27 20b. Place of Disp 20c. Location 20a. Method of Disposition Department of H importent: if ite eny injury or of ance. 1 Burial 2 Cremation 3 Removal from State 5 Other (Specify) 4 Donation 21. Signature of Funera Service Lic Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. ASCUD Immediate Cause (Final disease or condition resulting in death) Physician /Medical to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events ue to (or as a consequence of) Hospital or Attending Physician: The law requires thet the death certificate be executed buriai-transi Exami resulting in death) Last ending physician use as the burial P.O. Box 68760. Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4 Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part If. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. 2 3 Probably 1 ☐ Yes 2 ☐ No Completed peeu 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy No certificate 1 Yes After this certific funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes Hospital: 3 DOA 2 2 🗌 No 1 Inpatient 2 ER/Outpatient 28a. Date of Injury (Month, Day Year) 28b Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 10 Natural 5 Pending To the more after deam.
within 24 hours after deam.
To the Funeral Director; Alt 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28t. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 🔁 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifie Medical 2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 7 30. Name and address 31. Date filed (Month, Day, Year) State 7 2005 Registrar

|                |   |                | 1 - For<br>State<br>Registrar   | State of Ma                                      | -                      | epartmen<br>Certificat             |                          |                  | and Mer                        |                             | iene<br>g. No. | 05                                       | 41667                               |
|----------------|---|----------------|---|--|------------------------|------------------------------------|--------------------------|------------------|--------------------------------|-----------------------------|----------------|--|-------------------------------------|
|                | Physici   | an             | 1. Decedent's Name (First, Middle, Last,  | )  |                        |                                    |                          |                  |                                | Date of Deat<br>Month       | h<br>Day       | Year                                     | 3. Time of Death                    |
|                | /Medic  | al             | VERA  |  |                        |                                    | CKET                     |                  |                                | EMBER                       | 21             | 2005                                     | 11:24 P M                           |
|                | Examin  | er             | 4a. Facility Name (If not institution, give   |  |                        | BALT                               |                          | Location o       | of Death                       |                             | 4c. Co         | unty of Death                            |                                     |
|                | Funeral   |                | 5. Social Security Number 6. Se   |  | (In yrs. last birtl    | nday) If Under                     | 1 Year                   | If Under 2       |                                | Date of Birth               | Vans)          |  | place (State or Foreign<br>intry)   |
|                | Director  |                | 224· 60·2147 15   | ]M 220F  | ۰D Y                   | rs. Months                         | Days                     | Hours            | Min. 08                        | (Month, Day,<br>3 . 14 . 10 | 145            | Con                                      | VA                                  |
|                | pur *   |                | Usual Residence of Decedent  10a. State 10b. County   |  | 10c. City, Town        | or Location                        |                          |                  |                                |                             |                |  | 10d. Inside City Limits             |
|                | daryii<br>f sho   | ō              | MD N/A  |  | BALTIM                 | _                                  |                          |                  |                                |                             |                |  | 1 <b>G</b> Yes 2 □ No               |
|                | 28a-  | Director       | 10e. Street and Number  |  | DALITIVE               | 10f. Zip                           | Code                     |                  |                                | 1                           | 0g. Citizen    | of What Cou                              | intry?                              |
|                | th with   |                | 4010 ROSECREST  | AVENUE   |                        |                                    | 2121                     | 5                |                                |                             |                | USA                                      |                                     |
|                | ems er m  | Funerai        | 11. Marital Status  | 12. Was Decedent Ev<br>Armed Forces?             | ver in U.S.            | 13. Was Dece                       | dent of Hi               | spanic Orig      | gin? (Specify<br>, Puerto Rica | Yes or No-                  |                | Race - Amer<br>Black, White              |                                     |
| 36             | s afte  | by Fu          | 1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced  | 1 ☐ Yes 2 ☑ No<br>If Yes, Give<br>Year or Dates: |                        | 1 ☐ Yes                            |                          |                  |                                |                             | Sp             | ecify: BLF                               | Nov                                 |
| 21215-0036     | 72 hours after death with the Maryland<br>netural', or Items 23a or 28a-f show<br>discul Exania writnest be motified at | ed b           | 15. Decedent's Edu  | ication  | 16a.                   | Decedent's Usu                     | al Occupa                | ation            |                                |                             | 16b. Kind      | of Business/li                           |                                     |
| 215            | within 72<br>ene.<br>then "ne   | piet           | (Specify only highest grad<br>Elementary/Secondary (0-12)   | le completed) College (1-4or 5+                  | )                      | (Give kind of wo<br>life. DO NOT u | erk done d<br>se retired | luring most<br>) | of working                     |                             |                |  | _                                   |
| 21             | filed wit<br>Hygiene<br>other the   | Completed      | IR TH GRADE   | NA   |                        | COOK                               |                          |                  |                                |                             |                | SERVI                                    | CE                                  |
| and            | ld be fill<br>ental H<br>ked oth<br>ic even   | Be             | 17. Father's Name (First, Middle, Last)   |  |                        |                                    |                          |                  |                                | rst, Middle, M              |                | mame)                                    |                                     |
| Maryland       | 2 ≥ 2 ts  | ည              | JOHN H. DIGGS  19a. Informant's Name/Relationship (T)   | voe Print)                                       | 19b.                   | Mailing Address                    |                          |                  |                                | COTIRE                      |                | wn State Zi                              | in Code)                            |
| Ma             | and 2 sho<br>salth and<br>n 27 is m   |                | CECIL L. CROCKETT   | (HUSBAND)  |                        | O ROSEC                            |                          |                  |                                |                             | 10.21          |  | <i>p</i> 0000,                      |
| re,            | es 1 al<br>of Hea<br>f item<br>r othe   |                | 20a. Method of Disposition  |  | 20b. Place of          | Disposition (Nar                   | ne of                    |                  | Date                           |                             |                | ion - City or T                          | own, State                          |
| Ë              | Pag<br>nent<br>ant: I<br>ury o  |                | 1 ☑ Burial 2 ☐ Cremation 3 ☐ F  '4 ☐ Donation 5 ☐ Other (Specify)   |  | DRUID I                |                                    | ,                        |                  | 2 - 29 - 0                     | 5                           | PIKES          | VILLE,                                   | MD                                  |
| Baltimore,     | permit. Page<br>Department o<br>Important: If<br>any njury or<br>once.  |                | 21. Sign ture of Funeral Service Licens   |  |                        | 22. Name ar                        | d Addres                 | s of Facility    | UNERAL                         | SERVICE                     |                |  |                                     |
|                | 0.0 ≥ a o   | _              | Vauchn C.   | liantians that sound t                           | ha daath Da a          | 5151 BAL                           |                          |                  |                                |                             |                | 1  | Approximate                         |
| ı              | e 1.1   |                | 23a. Part1. Enter the disease, or compi<br>shock, or heart failure. List only o<br>Immediate Cause (Final   | ne cause on each line                            | ).                     | or enter the mod                   | ie or dynn               | y, sucii as i    | cardiac or re                  | spiratory arre              | 551,           |  | Interval Between<br>Onset and Death |
|                | Pnysician<br>/Medical   |                | disease or condition resulting in death)  |  | consequence o          |                                    |                          | -                |                                |                             |                |  | 1 day                               |
|                | Examiner  |                |   |  | ated 3                 |                                    | Fisher                   |                  |                                |                             |                |  | Lance                               |
|                | n =   | ner            | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury |  | consequence o          |                                    | 4 000 000                |                  |                                |                             |                |  |                                     |
|                | be executed<br>icien and<br>burial-transit  | Examine        | Cause (Disease or injury that initiated events resulting in death) Last                                     | c. Systemas                                      | consequence o          |                                    | ema                      | tosowa           |                                |                             | _              |  | years                               |
| 8760,          | ate be executed<br>hysicien and<br>the burial-transit   | cai E          |   | Due to (or as a                                  | consequence o          | 17.                                |                          |                  |                                |                             |                |  |                                     |
| 687            | P S   | edic           |   | d  |                        |                                    |                          |                  |                                |                             |                |  |                                     |
| Box            | death certifica<br>attending ph<br>d for use as th  |                | IF FEMALE: 23b. Was decedent pregnant   | 23c. If yes, outcome of<br>1 ☐ Live birth 2      |                        | 3 □Ectopic p                       | roananov.                |                  |                                |                             | 23d            | . Date of deliv                          | ,                                   |
|                | deat<br>death   | Physician/M    | in the past 12 months?<br>1 ☐ Yes 2 ☑ No  | 4☐Pregnant at ti                                 |                        | 5 Other (sp                        |                          |                  |                                |                             |                | Month                                    | Day Year                            |
| P.0            | that the de<br>led by the a<br>detached t   | Phy            | 9 ☐ Unknown ` Part II. Dther significant conditions co  |  | not resulting in       | the underlying o                   | Salleo Give              | on in Part I     |                                | 23a Did toh                 | acco usa       | contribute to                            | the cause of death?                 |
| ds,            | es<br>Deg   | d by           | Part II. Dation significant conditions co   | initiodaling to doddin but                       | . Hot rosulting in     | the underlying c                   | auso give                | or are care i.   |                                | 1 □ Ye                      |                |  | bably 4 Unknown                     |
| Vital Records, | w requir<br>been si<br>should   | Completed      |   |  |                        |                                    |                          |                  |                                | 24a. Was ar                 | 1 2            | 4h Were aut                              | opsy findings available             |
| Re             | has<br>has  | dmc            |   |  |                        |                                    |                          |                  |                                | autops<br>perforn           | y<br>ned?      | prior to co<br>death?<br>1 \(\sum \) Yes | ompletion of cause of               |
| ta             | ilcien: Th<br>certificate<br>rector, pag  | O              | 25. Was case referred to medical  |  |                        |                                    |                          | 26. Place        | of Death (C                    | 1 Yes 2                     | No No          | 1 LJ Yes                                 | 2 NO                                |
| of V           | dis di  | To B           | examiner?<br>1 ☐ Yes 2 X No   | lospital: 1 Inpatien                             | t 2 ER/Out             | patient 3 DC                       | Othe Othe                |                  |                                |                             |                | Other (Spec                              | ify)                                |
|                |   |                | 27. Manner of Death Natural 5 Pending   | 28a. Date of Injury<br>(Month, Day               | Year) 28b. Ti          | jury                               | 28c. Injury<br>Work      | at<br>?          | 28d.                           | Describe ho                 |                |  |                                     |
| Division       |   | icati          | 2 Accident investigation 3 Suicide 6 Could not be   | 28e. Place of Injur                              | v - At home for        | M street factor                    |                          | /es 2□N          |                                | Location (St                | reet and N     | umber or Rui                             | al Route Number,                    |
| Div            | l or Attendated after death   | Certification: | 4 ☐ Homicide determined   | building, etc.                                   | (Specify)              | in, street, lactor                 | y, onice                 |                  | 201.                           | City or Town                |                | arribor or ritar                         | ar riodio rioribor,                 |
|                | e Hospital<br>24 hours a<br>Funerel I<br>etely filled   | -              | 29a. Certifier 1 Certifying Phy   | sician: To the best of                           | my knowledge,          | death occurred                     | at the tim               | e, date and      | d place, and                   | due to the ca               | use(s) and     | d manner as                              | stated.                             |
|                | To the Hospital or At within 24 hours after of To the Funerel Direct completely filled in by                            | edic           | (Check only 2 Medical Exami   | ner: On the basis of e<br>and manner state       | examination and<br>ed. | /or investigation                  | , in my op               | oinion, deat     | th occurred a                  | it the time, da             | ate and pla    | ice, and due                             | to the cause(s)                     |
|                | To the h<br>within 2.<br>To the I   | Σ              | 29b. Signature and title of certifier   |  |                        | 29                                 | c. License               | number           |                                | 29                          | 9d. Date si    | igned (Month                             | , Day, Year)                        |
|                | (A  |                | Juno  |  |                        |                                    | RES                      |                  | 0                              | De                          | ELEMBI         | ER 21,                                   | 2005                                |
|                | 4   |                | 30. Name and address of person who co   |  | 61                     |                                    | LADIN                    | - 0.             | AUCS ON                        | 100                         |                | 117.07                                   | L                                   |
|                | Sta   | te             | 31 Date filed (Month Par Post) -  | 200 = 32. Resstrar                               | 's Signature           | MOLFE STR                          |                          | BM7              | IMORE                          | MARY                        | KNA            | 21287                                    |                                     |
|                | Registr   |                |   | 2005   | me It                  | Sport                              | م                        |                  |                                |                             |                |  |                                     |

|                            |  |                               | 1 - For State of Maryl   |                                       | rtment of H                            |                          |   | giene<br>Reg. No. 005        | 1668                                |
|----------------------------|--|-------------------------------|--|---------------------------------------|--|--------------------------|---|------------------------------|-------------------------------------|
|                            |  |                               | Decedent's Name (First, Middle, Last)  |                                       |  |                          | 2. Date of De.<br>Month                 | ath                          | 3. Time of Death                    |
|                            | Physici<br>/Medic  |                               | Wilbur F. Che  | telat, S                              | r.                                     |                          | Decem                                   |                              | 058:41 PM                           |
|                            | Examin   |                               | 4a. Facility Name (If not institution, give street and number)   | 2.61                                  | 4b. City, Town, or                     | Location of Dear         | th                                      | 4c. County of De             | ath O                               |
| 100                        |  | \$ P                          | Franklin Square HOSP<br>5. Social Security Number 16. Sex 7. Age (in)  | vrs. last birthday)                   | If Under 1 Year                        | If Under 24 Hrs          | R Date of Bird                          | Balti                        | inthplace (State or Foreign         |
| ib .                       | Funeral Director   |                               | 5. Social Security Number  | Yrs. Vrs.                             | Months Days                            | Hours Min                | 8. Date of Bin<br>(Month, Da<br>Jan. 12 | y, Year) 5. 0                | aryland                             |
|                            | D  |                               | Usual Residence of Decedent  |                                       |  | 11                       | <u> </u>                                | 7-5-5-                       |                                     |
|                            | arylar<br>show   | 7                             |  | c. City, Town or Loc                  |  | iddle Ri                 | ver                                     |                              | 10d. Inside City Limits             |
|                            | the M  | ecto                          | Maryland Baltimore   |                                       | 10f. Zip Code                          |                          |   | 10g. Citizen of What C       |                                     |
| 7                          | after death with the Maryland<br>or Itame 23s or 28s-f show<br>mitter a wat be matified at   | וסוי                          | 13 Cypress Lane  |                                       | , z.p 0000                             | 21220                    |   | United Sta                   | •                                   |
| 3                          | death  | nera                          | 11. Marital Status 12. Was Decedent Ever in Armed Forces?  | in U.S. 13. W                         | as Decedent of Hi<br>Yes, specify Cuba | ispanic Origin? (S       | Specify Yes or No                       | - 14. Race - Am<br>Black, Wh |                                     |
| 200                        | or Its   | y Fu                          | 1 ☐ Never Married 2 反 Married 1 ☐ Yes 2√1 No<br>If Yes, Give   |                                       | ☐ Yes 2 No                             | Specify:                 | to mount, otc.)                         | Specify                      |                                     |
| //<br>5-003                | n 72 hours after death with the Marylan<br>"naturel", or Itame 23s or 28s-1 show<br>citcal Examiner must be multified at   | d pe                          | 3 ☐ Widowed 4 ☐ Divorced Year or Dates:  15. Decedent's Education  | 16a Decedo                            | ent's Usual Occupa                     | ation                    |   | 16b. Kind of Busines         | White                               |
| 215                        | within 72<br>ene.<br>then "nat   | plet                          | (Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+)   | (Give k                               | and of work done of NOT use retired    | during most of wo        | rking                                   |                              | ,                                   |
| 212                        | giene<br>grene<br>er the   | Completed by Funeral Director | 12 Years   |                                       | Foreman                                |                          |   |                              | Industry                            |
| Sign                       | be filed<br>ital Hygi<br>d other<br>svent,   | Be                            | 17. Father's Name (First, Middle, Last)  |                                       |  |                          | me <i>(First, Middle,</i><br>el Mav J   | Maiden Sumame)               |                                     |
| N Sep                      | should be<br>ind Mental<br>marked o  | ٦                             | Frank Joseph Chetelat  19a. Informant's Name/Relationship (Type, Print) (Wife)   | 19h Mailine                           | Address (Street                        |                          |   | er, City or Town, State,     | Zin Code)                           |
| Le Ke                      | ith an It |                               | Mrs. Wilma Ruth Chetelat   |                                       | Cypress I                              |                          | ddle Riv                                | or MD                        | 220                                 |
| த் வ                       | s 1 and<br>f Health<br>Item 27<br>other to   |                               | 20a. Method of Disposition 20  | Ob. Place of Dispos<br>cemetery, crem | ition (Name of                         | e)                       | Date                                    | 20c. Location - City of      |                                     |
| CHE altimore,              | Pages<br>nent of<br>int: If it   |                               |  | Hilltop S                             |  |                          | /26/2005                                | Towson,                      | Maryland                            |
| alt:                       | permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygene. Important: If item 27 is marked other then any injury or other traumatic avent, the Manging.  |                               | 21. Signature of Funeral Service Licenses  | Du (                                  | Name and Address<br>da-Ruck I          | s of Facility<br>Tuneral | Home of                                 | Dundalk, I                   | nc.                                 |
| Δ.                         | 20 E # 9   |                               |  |                                       |  |                          |   | 7                            | 21222<br>Approximate                |
|                            |  |                               | 23a. Part1. Enter the disease, or complications that caused the c shock, or heart failure. List only one cause on each line.  Immediate Cause (Final | Jealin. Do not enter                  | r the mode of dylin                    | g, such as cardia        | c or respiratory ar                     | 1851,                        | Interval Between<br>Onset and Death |
|                            | Physician<br>/Medical  |                               | disease or condition resulting in death)   | CID V LS                              | cular                                  | Collays                  | 3 (                                     |                              |                                     |
|                            | Examiner   |                               | Carl   | e hy                                  | media                                  | - Duc                    | 0011                                    |                              |                                     |
|                            | D =  | ner                           | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.                 | isequen e of):                        | A TANK MANAGEMENT                      | 1014                     | 1.77                                    |                              |                                     |
| 10                         | be executed<br>icien and<br>buríal-transit   | Examiner                      | Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as erctin  | Cr Tyras                              | ~                                      |                          |   |                              |                                     |
| 760,                       | be exicien s   | cal E                         | Due to (or as grown  | isequence or):                        |  |                          |   |                              |                                     |
|                            | ficate<br>phys<br>s the  |                               | d  |                                       |  |                          |   |                              |                                     |
| P.O. Box 68                | The law requires that the death certifica<br>tte has been signed by the attending ph<br>bage 2 should be detached for use as th  | Physician/Med                 | IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pre  |                                       | Ectopic pregnancy                      |                          |   | 23d. Date of de              | elivery                             |
| B                          | death  | sicia                         | in the past 12 months?  1   Yes 2   No   |                                       | Other (specify)                        |                          |   | Month                        | Day Year                            |
| P.O                        | d by the   | Phy                           | 9 Unknown  Part II. Other significant conditions contributing to death but not   | t consideration in the con-           | dashina anyan ay                       | en in Doet I             | 22a Did to                              | bacco use contribute         | to the eques of death?              |
| ds,                        | signe<br>d be d  | by                            | - / . w / Disease  | , resulting in the and                | denying cause give                     | minraiti.                | 1 🗆 1                                   | _ ~                          | Probably 4 Unknown                  |
| Sorie                      | w requ   | etec                          | - Light Oisens   |                                       |  |                          | 24a. Was                                | an 24h Were a                | utopsy findings available           |
| Re                         | he lav<br>e has  | Completed                     | - Colori Cancer  |                                       |  |                          | autop                                   | sy prior to death?           | completion of cause of              |
| tal                        | en: T<br>tificat<br>tor, pa  | 0                             | 25. Was case referred to medical   |                                       |  | 26. Place of De          | 1 ☐ Yes<br>ath (Check only o            |                              | s 2□ No                             |
| Division of Vital Records, | hystoi<br>his cei<br>I direc   | To B                          | examiner? 1 Tyes No Hospital: 1 Inpatient  | 2 ER/Outpatient                       |  | 4 🗀 Nursing r            | Home 5□ Resid                           | lence 6 ⊟Other (Sp.          | ecify)                              |
| 0 0                        | ing Pl   |                               | 27. Manner of Death 28a. Date of Injury 1 Natural 5 ☐ Pending (Month, Day Yea  | 28b. Time of Injury                   | 28c. Injury<br>Work                    |                          | 28d. Describe h                         | ow injury occurred           |                                     |
| isio                       | ttend<br>death<br>stor: /<br>the f   | icati                         | 2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury.   | At home farm stre                     |  | Yes 2 □No                | 28f Location /S                         | Street and Number or F       | Rural Boute Number                  |
| Div                        | after<br>Direct  | Certification:                | 4 Homicide determined building, etc. (Sp   | pecify)                               | ot, ractory, cince                     |                          | City or Ton                             |                              | idia / iddo / idiiso/               |
|                            | To the Hospitel or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death.  within 24 hours after death.  To the Funset Director: After this certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit  | edical C                      | 29a. Certifier (Check only 2 Medical Examiner: On the basis of exam  | knewledge dalith                      | ophumed at the tim                     | ia date and class        | a and due to the o                      | tause(s) and trainer a       | s stated.                           |
|                            | the<br>hin 24<br>the<br>mplete   | Medi                          | one) and manner stated.  |                                       | 29c. License                           |                          |   | 29d. Date signed (Mon        |                                     |
|                            | To wit   | _                             | 29b. Signature and title of certifier  | SIL                                   | 29C. License                           | - 1 2 2                  | 3                                       | 17 17                        | 161                                 |
|                            | 0,   |                               | 30. Name and address of person who impleted cause of death (   | (Item 23a) (Type. F                   |  |                          | 2                                       | 101                          | -1103                               |
| _                          | 10   |                               | Draa Militai 1605 W  | : Point                               |  | 708,                     | 3alti-                                  | all mo                       | ,21224                              |
|                            | Sta  | - 200                         | 31. Date filed (Month, Day, Year) 32. Registrar's S  | ignature                              | ( . W .                                |                          |   |                              | J                                   |
| II.S                       | Registr  | दा                            | DEC 2 7 2005   | 1 13. 19                              | 2042                                   |                          |   |                              |                                     |

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ORIGINAL

|                            |   |                  | _ For  | State of Ma  | aryland / D          | epartmen  | t of H                  | ealth and                        | _                               | Hygien                             | en 0.5                     | To the same of the | 569             |
|----------------------------|---|------------------|--|--|----------------------|---|-------------------------|----------------------------------|---------------------------------|------------------------------------|----------------------------|--|-----------------|
|                            |   |                  | State Registrar Amend Ttem  1. Decedent's Name (First, Middle, Last)   | 8 Per F  | I G850 1             | 2729/05   | e JH                    | Jean                             | 2. Date                         | Reg. W                             | 0.                         | 3 Tim  | e of Death      |
|                            | Physici   | an.              | Birdie Belle Davis   | 3  |                      |   |                         |                                  | Monti<br>12                     |                                    | 3 Yea                      | r  | 0 P.M.          |
| 1                          | /Medio  | 20.00            | 4a. Facility Name (If not institution, give st   |  |                      | 4b. City,   | Town, or                | Location of De                   |                                 |                                    | c. County of De            |  | .0 1 •111•      |
|                            | EXAMIL  | er<br>Ser        | Apt. #301, 11630 (   |  | Road                 | G   | len A                   | \rm                              |                                 |                                    | Baltimo                    | re   |                 |
|                            | Funeral   |                  | 5. Social Security Number 6. Sex   | 7. Ag  | θ (In yrs. last birt | hday) If Under  | 1 Year                  | If Under 24 H                    | in. 8. Date                     | of Birth<br>h, Day, Year<br>28,19  |                            |  | ate or Foreign  |
|                            | Director  |                  | 192-12-3/19  | M XXF  | 82                   | Yrs.  |                         |                                  | Dec                             | .28,19                             | <b>22</b>   Pe             | nnsylv   |                 |
|                            | and and   |                  | Usual Residence of Decedent  10a. State 10b. County  |  | 10c. City, Town      | or Location   | <u> </u>                |                                  |                                 |                                    |                            | 10d. Insid   | e City Limits   |
|                            | Maryl<br>f sho  | ō                | Maryland Baltimore   |  | Glen                 | Arm   |                         |                                  |                                 |                                    |                            | 10   | Yes XX No       |
|                            | death with the Maryland<br>ome 23a or 28a-f show<br>ir must be notified at  | Funeral Director | 10e. Street and Number   |  |                      | 10f. Zip  | Code                    |                                  |                                 | 10g. C                             | itizen of What (           | Country?   |                 |
|                            | th wit  | aiD              | Apt. #301, 11630 (   | Glen Arm   | Road                 |   | 210                     |                                  |                                 |                                    | ted Sta                    | tes  |                 |
|                            |   | nue              | 11. Marital Status   | <ol><li>Was Decedent  <br/>Armed Forces?</li></ol> | Ever in U.S.         | 13. Was Deced   | dent of Hi<br>cify Cuba | spanic Origin?<br>n, Mexican, Pu | (Specify Yes<br>erto Rican, etc | or No-                             | 14. Race - An<br>Black, Wh |  | ٦,              |
| 36                         | hours after<br>ural', or its  |                  | 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced   | 1 ☐ Yes 2 ☐ N<br>If Yes, Give A<br>Year or Dates:  | No                   | 1 ☐ Yes   | 2 <b>∑</b> No           | Specify:                         |                                 |                                    | Specify: W                 | hite   |                 |
| 21215-0036                 | 72 hours<br>"natural",  | Completed by     | 15. Decedent's Educa   | ation  | 16a.                 | Decedent's Usua                                       | al Occupa               | ation                            |                                 | 16b. l                             | Kind of Busines            | s/Industry   |                 |
| 215                        | hin 72<br>8.<br>In "na<br>Medic   | pie              | (Specify only highest grade<br>Elementary/Secondary (0-12)   | completed) College (1-4or 5                        | 5+)                  | Decedent's Usua<br>(Give kind of wo<br>life. DO NOT u | rk done d<br>se retired | furing most of v<br>)            | vorking                         | 0-                                 | . 17                       |  |                 |
| 2                          | be filed within 72 hc<br>ital Hygiene.<br>Id other than "natur<br>event, the Medical  | Con              | 12   | (N/A)  | H                    | omemaker  | =                       |                                  |                                 |                                    | n Home                     |  |                 |
| pu                         | d oth   | Be               | 17. Father's Name (First, Middle, Last)  |  |                      |   |                         |                                  | lame (First, M                  |                                    | n Surname)                 |  |                 |
| yla                        | 2 should be<br>and Mental<br>is marked<br>sumatic ev  | T <sub>0</sub>   | John Heron   | a Reject   | 10h                  | Mailing Address                                       | /Stroot :               |                                  | ide Ost                         |                                    | or Town State              | Zin Codel  |                 |
| Maryland                   | s 1 and 2 should<br>t Health and Mer<br>tom 27 is marke<br>other traumatic  |                  | 19a. Informant's Name/Relationship (Type<br>Nancy Anne Davis Me  |  |                      |   |                         |                                  |                                 |                                    |                            |  | 1057            |
|                            | Heal<br>Heal<br>tem 2   |                  | 20a. Method of Disposition   |  | 20b. Place of        | Disposition (Nar<br>y, crematory or o                 |                         |                                  | Date                            |                                    | ocation - City of          |  |                 |
| ομ                         | Pages<br>ment of<br>ant: If It<br>ury or o  |                  | 1 Burial 2 ☐ Cremation 3 ☐ Re<br>4 ☐ Donation 5 ☐ Other (Specify)  | moval from State                                   |                      | y, crematory or d<br>Bank Cen                         |                         |                                  | 2/27/05                         | Gree                               | enfield                    | Towns  | hip Pa.         |
| Baltimore,                 |   |                  | 21. Signature of Funeral Service Licensee  | ,  |                      | 22 Name ar  | nd Addres               | s of Facility                    |                                 |                                    |                            |  | •               |
| m                          | Depar<br>Impo   |                  | I foun of te   | m  |                      | 2325 Yo   | ork R                   | ternat<br>load Tii               | iveş fu<br>nonium               | neralo<br>Maryla                   | Cremat<br>and 210          | 10n Ce<br>93   | nter            |
| 9 50                       |   |                  | 23a. Part1. Enter the disease, or complic shock, or heart failure. List only one   |  |                      | not enter the mod                                     | le of dyin              | g, such as card                  | iac or respirat                 | ory arrest,                        |                            | Approxi  | mate<br>Between |
| 1                          | Physician   |                  | Immediate Cause (Final disease or condition  | CERE   | = BRO                | VASCI   | ULA                     | P (                              | 7 cci                           | DEN                                | 7                          |  | ind Deathy      |
| 6                          | /Medical<br>Examiner  |                  | resulting in death)  | Due to (or as                                      | a consequence        | 3: 1  | OTI                     | ERY                              | CT                              | 7 11 6                             | 212                        | EV   | & ARS           |
|                            | Examine:  | -                | Sequentially list conditions, b.   |  | a consequence        | 4)  | KII                     |                                  | 218                             | 10 0                               | <u> </u>                   | 1 0 1  | 6-1115          |
| H                          | ted<br>nsit   | nine             | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c. | AT   | HERI                 |   | 5                       | ROSI                             | 5                               |                                    |                            | 25   | 1 GARS          |
| Ć.                         | be executed<br>ician and<br>burial-transit  | Examiner         | resulting in death) Last   |  | a consequence        | of):  |                         |                                  |                                 |                                    |                            | 000  | VEARL           |
| 120                        | 9 8 9   | cal              | d.   | H 4  | PIZR                 | LIPI  | <b>y</b> (2             | MII                              | M                               |                                    |                            | 90   | I CH19          |
| 89                         | The law requires that the death certificate E<br>tie has been signed by the attending physic<br>age 2 should be detached for use as the b | Physician/Medi   | IF FEMALE:   |  |                      |   |                         |                                  |                                 |                                    |                            |  |                 |
| Вох                        | ath ce  | lan/             | 23b. Was decedent pregnant in the past 12 months?  |  | 2 Fetal death        |   |                         |                                  |                                 |                                    | 23d. Date of d<br>Month    | elivery<br>Day   | Y <i>e</i> ar   |
|                            | the a   | ysic             | 1 ☐ Yes 2 DNo<br>9 ☐ Unknown   | 4□Pregnant at<br>9□ Unknown                        | time of death        | 5 🗌 Other (sp   | pecity)                 |                                  |                                 |                                    |                            |  |                 |
| P.0                        | res that the deligned by the be detached  |                  | Part II. Other significant conditions cont   | ributing to death b                                | ut not resulting in  | the underlying o                                      | ause give               | en in Part I.                    | 23e.                            | Did tobacco                        | use contribute             | to the cause   | of death?       |
| ds                         | uires<br>n sign<br>lld be   | d b              | CORONARY AR  | TERY   | DICE                 | ASE   |                         |                                  | _                               | 1 ☐ Yes 2                          | No 3□1                     | Probably 4   | □Unknown        |
| Ö                          | s been si   | olete            | ITYPER TEN   | 4012   | ART                  | RHYT  | -HV                     | MA                               |                                 | Was an                             | 24b. Were                  | autopsy findi  | ngs available   |
| Division of Vital Records, | The law<br>ate has<br>page 2:   | Completed by     | DIAGETES   | MELL   | 1 TUS                | TYPO  | 77                      | -                                | 101                             | autopsy<br>performed?<br>′es 2.2™N | death?                     | completion<br>s 2 No   | or cause or     |
| ital                       | 10 -  | BeC              | 25. Was case referred to medical examiner?   |  |                      |   |                         |                                  | Death (Check                    |                                    |                            |  |                 |
| × ×                        | Physician:<br>r this certific<br>ral director,  | 2                | 1 ☐ Yes 2 No   | spital: 1   Inpatie                                |                      | tpatient 3 DC   |                         | - I 14013111                     |                                 |                                    | 6 □Other (Sp               | pecify)  |                 |
| no<br>O                    | e di e  | ion:             | 27. Manner of Death 1 Natural 5 □ Pending  | 28a. Date of Inju<br>(Month, Da                    | y Year) 28b. 1       | ime of a finding M                                    | 28c. Injun<br>Work      | rat<br><br Yes 2 □ No            | 28d. Desc                       | ribe how inju                      | iry occurred               |  |                 |
| isic                       | Attending in death.  ctor: After by the fune.   | icat             | 2 Accident investigation 3 Suicide 6 Could not be  | 28e Place of Ini                                   | ury - At home, fa    |   |                         | 165 2 140                        | 28f. Local                      | ion (Street a                      | nd Number or i             | Rural Route I  | Vumber.         |
| Div                        | after<br>Direction by   | Certification:   | 4 ☐ Homicide determined  | building, et                                       | c. (Specify)         | ,   | y, ooo                  |                                  |                                 | r Town, Stai                       |                            |  |                 |
|                            | To the Hospital or Attandi<br>within 24 hours atter death.<br>To the Funeral Director: A<br>completely filled in by the fu                |                  | 29a. Certifier 1 Certifying Physi  | cian: To the best                                  | of my knowledge      | , death occurred                                      | at the tim              | ne, date and pla                 | ace, and due to                 | the cause(                         | s) and manner              | as stated.   |                 |
|                            | the Ho<br>hin 24 I<br>the Fu  | Medicai          | (Check only 2 Medical Examinations)  | er: On the basis of<br>and manner sta              |                      |   |                         |                                  | ccurred at the                  |                                    |                            |  |                 |
|                            | To the To the comp  | Σ                | 29b. Signature and title 6 curtifier   | 1  |                      | MD 29   | c. License              | number                           | 0                               | 29d. D                             | ate signed (Moi            | nth, Day, Yea  | (r)             |
|                            | $\mathcal{T}_i$   | 1                | Kin  | manay  | Pallen               |   | ِ سِل                   | 3162                             | 8                               | 10                                 | (1241                      | 200  | خ د             |
|                            | 10  |                  | 30, Name and address of person who con   | npleted cause of d                                 | eath (Item 23a) (    | Туре, РП)   | LIN                     | a (Ros                           | CROA                            | DS#                                | 159 3                      | ALTIN  | 10RE            |
|                            | Sta   | te               | 31. Date filed (Month, Day, Year)  | 32. Registr  | ar's Signature       | 1 100   | - / 1/                  | 01 01                            | ,                               | · /                                | 1 - /                      | 114  |                 |
| 4.4                        | Registi   |                  | 31. Date filed (Month, Day Year) DEC 2 7 20  | 05   | we St.               | goode   |                         |                                  |                                 |                                    |                            |  |                 |

|                |   |                | State C  |   | artment of Health and  | - /                                      | 2005 !                          | . 1670  |
|----------------|---|----------------|--|---|--|--|---------------------------------|---|
|                |   |                | 1. Decedent's Name (First, Middle, Last)                                   | Ce  | rtificate of Death   | Reg.                                     | · UU Lon                        | 3. Time of Death                              |
|                | Physici   |                |  |   |  | Month<br>December                        | Day Year 17. 2005               | 7:00 A <sup>M</sup>                           |
|                | /Medio<br>Examin  |                | Bertha A. Davis  4a. Facility Name (If not institution, give street and nu | ım <i>ber)</i>  | 4b. City, Town, or Location of De                                      |  | 4c. County of Death             |   |
|                | LXaiiiii  |                | Heartland Nursing Home   |   | Hyattsville  | 1  | Prince Geo                      | rge's   |
| Т              | Funeral   |                | 5. Social Security Number 6. Sex 1 ☐ M 250F                                | 7. Age (In yrs. last birthday)                        | If Under 1 Year If Under 24 H<br>Months Days Hours Mi                  | rs. 8. Date of Birth<br>(Month, Day, Y   | ear) 9. Birth                   | place (State or Foreign<br>intry)             |
|                | Director  |                | 220-32-7366 Usual Residence of Decedent                                    | 93 Yrs.   |  | Feb. 2, 1                                | 1912 Wash                       | ington, DC                                    |
|                | land ow   |                | 10a. State 10b. County   | 10c. City, Town or Lo                                 | ocation  |  |                                 | 10d. Inside City Limits                       |
|                | Many<br>1-1 sh  | ţ              | Maryland Prince George'  | s Hyattsvi  | 11e  |  |                                 | 1 ☐ Yes 2 ☐ Wo                                |
|                | or 28   | Directo        | 10e. Street and Number   |   | 10f. Zip Code  | 10g                                      | . Citizen of What Cou           | intry?  |
|                | ath w   |                | 3705 Nicholson St.   |   | 20782  |  | U.S.A.                          |   |
|                | ltems   | Funeral        | Armed F  | cedent Ever in U.S. 13. forces?                       | Was Decedent of Hispanic Origin?<br>If Yes, specify Cuban, Mexican, Pu | (Specify Yes of No-<br>erto Rican, etc.) | 14. Race - Amer<br>Black, White |   |
| 3              | within 72 hours after death with the Maryland<br>ene.<br>than "natural", or items 23a or 28a-f show<br>he Medical Eval: it at mast to inclibed at   | by F           | 3 ⊠ Widowed 4 □ Divorced Year or I   | ive   | 1 ☐ Yes 2 ☑ No Specify:  |  | Specify: Whi                    | te  |
| 215-0036       | 72 hou  | ted            | 15. Decedent's Education<br>(Specify only highest grade completed,         |   | dent's Usual Occupation skind of work done during most of w            | yorkina 16                               | b. Kind of Business/I           |   |
| Z              | ithin 7   | Completed      | Elementary/Secondary (0-12) College  | (1-4or 5+) life.                                      | DO NOT use retired)  |  | . 1 1 . 0                       |   |
| N              | be filed within 72 hours after death with the Marylan stal Hygliene. Id other than "natural", or Items 23a or 28a-1 show other than "natural", or Items 23a or 28a-1 show event, the Medical Eval. it after neat the multiple |                | 12 17. Father's Name (First, Middle, Last)                                 | 61  | erk 18 Mother's N  | lame (First, Middle, Ma                  | ederal Gov                      | ernment                                       |
| and            | d be f  | To Be          | Wilber S. Dodge  |   |  | e Harvey                                 |                                 |   |
| Maryland       | s 1 and 2 should be f<br>Health and Mental I<br>item 27 Is marked of<br>other traumatic eve   | ř              | 19a. Informant's Name/Relationship (Type, Print)                           | 19b. Mail   | ng Address (Street and Number or                                       | <del>-</del>                             | City or Town, State, Zi         | ip Code)                                      |
|                | 5 = 2 I   |                | Geraldine_Wilson/daughte   |   | Nicholson St. H  | yattsville,                              | MD 20782                        |   |
| Baltimore,     | es 1 a<br>of Hea<br>fitem<br>r othe   |                | 20a. Method of Disposition  1XBurial 2 ☐ Cremation 3 ☐ Removal from        | 20b. Place of Disposer State                          | osition (Name of matory or other place)                                | Date 20                                  | c. Location - City or T         | own, State                                    |
| Ĕ              | permit. Pages<br>Department of I<br>Important: If ite<br>any injury or or<br>once.  |                | * 4 □Donation 5 □ Other (Specify)  | Fort Lin  | coln Cemetery 12   |  |                                 |   |
| g              | permit<br>Depar<br>Impor<br>any in<br>once.   |                | 21. Signature of Funeral Service Licensee                                  | 1/1/  | 2. Name and Address of Facility F                                      |  |                                 |   |
|                |   |                | 23a. Part1. Enter the disease, or complications that                       |   | 401 Bladensburg ter the mode of dving, such as card                    |  |                                 | Approximate                                   |
| 3              |   |                | shock, or heart failure. List only one cause on<br>Immediate Cause (Final  | each line.  | EIMERS DEN   |  |                                 | Interval Between<br>Onset and Death           |
|                | Physician<br>/Medical   |                | disease or condition resulting in death) a. Due to                         | (or as a consequence of):                             | TIMERS JEN   | 1601114                                  |                                 |   |
|                | Examiner  |                | Sequentially list conditions D.  |   |  |  |                                 |   |
|                | p ti  | iner           |  | o (or as a consequence of):                           |  |  |                                 |   |
|                | law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the buriat-transit  | Examiner       | that initiated events c  | (or as a consequence of):                             |  |  |                                 |   |
| 8/60,          | be e.<br>sician<br>buria  | icai E         |  |   |  |  |                                 |   |
| 28             | ificate I<br>g physi<br>as the t  | 0              | 0.   |   |  |  |                                 |   |
| ROX            | eath certific<br>attending p<br>I for use as 1  | Physician/Me   | 23b. Was decedent pregnant   | utcome of pregnancy<br>birth 2 Detail death 3         | □Ectopic pregnancy   |  | 23d. Date of deliv              | *   |
|                | e deat<br>he att  | sicis          | In the past 12 mouths?  1 ☐ Yes 2√2 No Q☐ Link                             | gnant at time of death 5                              | Other (specify)  |  | Month                           | Day Year                                      |
| J.             | res that the de<br>signed by the a<br>l be detached f   |                | 9 ☐ Unknown  Part II. Other significant conditions contributing to         | death but not resulting in the                        | inderlying cause given in Part I                                       | 23e. Did tobac                           | co use contribute to            | the cause of death?                           |
| ds,            | signe<br>d be c   | d by           |  |   | DISCASE  |  | 2 □ No 3 □ Pro                  | _   |
| 000            | w require<br>been si<br>should b  | lete           | 17.03.074  | 1 BRTERY<br>ENSION                                    |  | 24a. Was an                              | 24b. Were aut                   | opsy findings available                       |
| Vital Records, | 9 9   | Completed      | 10/1-61-11   | <i></i>   |  | autopsy<br>performe<br>1 ☐ Yes 2 5       | d?// death?                     | opsy findings available ompletion of cause of |
| <u> </u>       | ician: Th<br>certificate<br>rector, pag   | 0              | 25. Was case referred to medical   |   | 26. Place of D   | eath (Check only one)                    | F140 12.100                     | 20110   |
| 01 <           | Physici<br>this ce<br>al direc  | To B           |  | Inpatient 2 ER/Outpatie                               |  | Home 5 Residence                         | ce 6 □Other (Spec               | ify)  |
| 0              | ding Pt<br>n.<br>After th<br>funeral  |                | Januardian Serioning   | e of Injury<br>onth, Day Year) 28b. Time of<br>Injury | Work?  | 28d. Describe how                        | injury occurred                 |   |
| Division       | Vttendi<br>death.<br>ctor: A<br>y the fu  | icat           | 2 Accident investigation 3 Suicide 6 Could not be 28e Place                | ce of Injury - At home, farm, st                      |  | 28f. Location (Stree                     | et and Number or Rui            | al Route Number.                              |
| 2              | To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.   | Certification: | 4 Homicide determined 289. Flat built                                      | ding, etc. (Specify)                                  | root, radioly, onloo   | City or Town, S                          |                                 |   |
|                | To the Hospital or A within 24 hours after To the Funeral Direct completely filled in by  |                |  |   | th occurred at the time, date and pla                                  |  |                                 |   |
|                | the Ho<br>in 24<br>the Fu<br>ipletel  | ledicai        | one) and ma  | nner stated.  | nvestigation, in my opinion, death or                                  |  |                                 |   |
|                | with To I   | Σ              | 29b. Signature and title of certifier                                      |   | 29c. License number  |  | Date signed (Month              |   |
|                | , *   |                | 7 very   | M D   | D60283   | 40                                       | 12/21/0                         | >   |
|                | 10  |                | 30. Name and address of person who completed can SUR CSHKUMAN MUTT         |   | QUEENSBUR  | Y RO. 144                                | ATTSVILL                        | E Mn and                                      |
|                | Sta   | ate            | 31. Date filed (Month. Day, Year) 324                                      | Registrar's Signature                                 | a colony   |  |                                 | - 101.) 4010                                  |
|                | Regist  | rar            | DEC 2 7 2005   | was the pay   | ed .   |  |                                 |   |

MICHAEL A. DAILEY 05-08604 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Unpend item#23a,27,pen/le (351,1/25/06 TT State of Maryland / Department of Health and Mental Hygiene 15 RKD 1 - For State Registra Certificate of Death Rag. No. 2. Date of Death 3. Time of Death DECEMBER 20, 2005 **Physician** 9:50A. /Medical 4b. City. Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number, Examiner NORTHWEST REGIONAL HOSPITAL RANDALLSTOWN BALTIMORE If Under 1 Year II Under 24 Hrs.
Months Days Hours Min. 7. Age (In yrs. last birthday). 8. Date of Birth Month, Day, 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** Months M 2□ F 218-72-733 Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits or 28a-f ehow permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryls Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or iteme 23a or 28a-1 ehos any Injury or other traumatic event, the Medical Examinal must be notified at once. Baltimore 1 ☐ Yes 2 No Completed by Funeral Director Kes vi 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21208 Dad 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1□Yes 💥 No Baltimore, Maryland 21215-0036 Specify. Klack 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry done during most of working College (1-4or 5+) Elementary/Secondary (0-12) 17. Father's Name (First, Middle, Last) Be ပ္ tram ame/Relationship (Type City or Town, Stat Zp Code) Method of Disposition 1 Burial 2 □ Cremann. — 4 □ Donation 5 □ Other (Specify) 3 ☐Removal from State une Service 21. Sinn ure of 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Acute: pancreatitis /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): igned by the attending physicien end be detached for use as the burial-transit or Attending Physician: The law requires that the death certificete be executed Due to (or as a consequence of): Box 68760. Certification: To Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Day Month Year 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown 9 ☐ Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 🗷 No 3 Probably 4 Unknown cete has been signate, page 2 should b 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificete 2□ No N Yes 2□ No 1 XYes nerel Director: After this certific filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Yes 1 Inpatient 2 ☐ ER/Outpatient 3 X DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital o within 24 hours aft To the Funerel Di completely filled in 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier DECEMBER 21, 2005 NUD O.C.M.E. who completed cause of death (Item 23a) (Type, Print) 111 PENN STREET BALTIMORE MARYLAND 21201 32. Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 05 41672

|  |                | 1 - State<br>Registrar  |  | C                              | ertificate of   | Death                             |  | Reg. No.                         |                              |  |
|--|----------------|---|--|--------------------------------|---|-----------------------------------|--|----------------------------------|------------------------------|--|
| *  |                | Decedent's Name (First, Middle, La  | ast)   |                                |   |                                   | 2. Date of De                                | ath                              |                              | 3. Time of Death                       |
| Physic   |                |   | Stephen A  | lphonse                        | Denisuk   |                                   | Decemb                                       | er 22,                           | Year 2005                    | 2:30 P M                               |
| /Med<br>xami   |                | 4a. Facility Name (If not institution, gir  |  |                                | 4b. City, Town, o   | or Location of [                  |  |                                  | ty of Death                  |  |
| ă.   | 380            | 1514 Rita Road  | 1  |                                | Dund  | alk                               |  | Ва                               | iltimo                       | re Co.                                 |
| era  |                |   | Sex 7. Age   | (In yrs. last birthda          | y) If Under 1 Year<br>Months Days                                     |                                   | Hrs. 8. Date of Bir<br>Min. (Month, Da       | th<br>V Year)                    | 9. Birthp                    | place (State or Foreign                |
| cto  |                | 218-18-4005   | <b>¥S</b> xM 2□F 82  | Yrs.                           | MOIIIIS Days  | riours                            | July   | 11,1923                          | Mar                          | yland                                  |
|  |                | Usual Residence of Decedent   |  |                                |   |                                   |  |                                  |                              |  |
| other traumatic event, the Mactical Examiner That of notified at | h              | 10a. State 10b. County  |  | 10c. City, Town or             | Location  | _                                 |  |                                  | 1                            | 10d. Inside City Limits 1 ☐ Yes 2 🛣 No |
|  | 5              | Maryland Bal  | timore   |                                |   | D                                 | undalk                                       |                                  |                              |  |
|  | Director       | 10e. Street and Number  |  |                                | 10f. Zip Code   | 01000                             |  | 10g. Citizen o                   | f What Cour                  | ntry?                                  |
|  | al             | 1514 Rita Road  |  |                                |   | 21222                             |  |                                  | ted St                       |  |
|  | Funeral        | 11. Marital Status  | 12. Was Decedent En  | ver in U.S. 1                  | <ol><li>Was Decedent of F<br/>If Yes, specify Cub</li></ol>           | Hispanic Origin<br>an, Mexican, F | n? (Specify Yes or No<br>Puerto Rican, etc.) | )- 14. Ra                        | ace · Americ<br>lack, White, |  |
|  | by Fu          | 1 Never Married 2 Married   | NOTYes 2 No  | wwii                           | 1 ☐ Yes 2 🔼 No  | Specify:                          |  | Spec                             | ify: W                       | hite                                   |
|  |                | 3 XWidowed 4 □ Divorced   | Year or Dates:   |                                |   |                                   |  |                                  |                              |  |
|  | Completed      | 15. Decedent's E<br>(Specify only highest gi  | ducation<br>ade completed)   | (G.                            | cedent's Usual Occup<br>ive kind of work done<br>e. DO NOT use retire | during most o                     | f working                                    | 16b. Kind of                     | Business/In                  | idustry                                |
|  | E D            | Elementary/Secondary (0·12)   | College (1-4or 5+  | )                              | General I   |                                   | 1  | Ste                              | el In                        | dustry                                 |
|  |                | 12 Years 17 Father's Name (First, Middle, Las   | <i>t</i> )   |                                | General   |                                   | s Name (First, Middle                        | Maiden Sum                       | ame)                         | -                                      |
|  | Be             |   |  |                                |   |                                   | •  |                                  | 11107                        |  |
|  | ို             | Steven Denisuk  |  | 405.14                         |   |                                   | coinette D                                   |                                  | - 01-1- 7:                   | - 0-4-1                                |
|  | 1              | 19a. Informant's Name/Relationship  |  |                                |   |                                   | or Aural Route Numb<br>Idalk, Mar            |                                  |                              | o Code)                                |
|  |                | Jeffrey T. Denis  | uk (5011)  | _                              | sposition (Name of  | 10 Dui:                           | Date   | 20c. Location                    |                              | own State                              |
|  |                | 20a. Method of Disposition 1 ⊠ Burial 2 □ Cremation 3 l   | ☐Removal from State  | cemetery, c                    | rematory or other pla   |                                   |  |                                  |                              |  |
|  | -              | 4 □ Donation 5 □ Other (Spec  | _  | Sacred                         |   |                                   | 12/27/20                                     | 05 D <b>u</b> n                  | dalk,                        | Maryland                               |
|  |                | 21. So ature of Funeral Service Line  | intee /  | 6                              | 22. Name and Addre Duda-Ruck  | Funera                            | al Home of                                   | Dundal                           | k, In                        | C •                                    |
|  |                | 1)  | (an  |                                | 7922 Wise   | e Ave.                            | Dundalk,                                     | Maryla                           | nd 2                         | 1222                                   |
|  |                | 23a. Part1 Enter the disease, or cor<br>shock, or heart failure. List only                                  | nplications that caused to<br>one cause on each line               | he death. Do not               |   |                                   |  |                                  |                              | Approximate<br>Interval Between        |
|  |                | Immediate Cause (Final disease or condition   | META   | STATI                          | O. RE   | CIA                               | C CAI  | VCER                             |                              | Onset and Death                        |
| Į  |                | resulting in death)   | Due to (or as a  | consequence of):               |   |                                   |  |                                  |                              |  |
|  |                | Sequentially list conditions  | b  |                                |   |                                   |  |                                  |                              |  |
|  | ner            | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | Due to (or as a  | consequence of):               |   |                                   |  |                                  |                              |  |
|  | Examiner       | that inflated events  | c  |                                |   |                                   |  |                                  |                              |  |
|  |                | resulting in death) Last  | Due to (or as a  | consequence of):               |   |                                   |  |                                  |                              |  |
|  | Ica            | •   | d  |                                |   |                                   |  |                                  |                              |  |
|  | Medical        | IF FEMALE:  |  |                                | ,                               |                                   |  |                                  |                              |  |
|  |                |   | 23c. If yes, outcome of<br>1□Live birth 2                          | ☐Fetal death                   | 3 □Ectopic pregnanc   | у                                 |  |                                  | Date of delive<br>Month      | ery<br>Day Year                        |
|  | SC             | 1 Yes 2 No  | 4□Pregnant at t<br>9□Unknown                                       | me of death                    | 5 Other (specify)   |                                   |  | "                                |                              | July 1 dai                             |
|  | Physician      | 9 Unknown   |  |                                |   |                                   | 00- 011                                      | lohana                           | atab to to                   | ha course of de the                    |
|  | ğ              | , arm stier significant contains  | contributing to death but  | not resulting in the           | e underlying cause gr   | ven in Part I.                    |  |                                  |                              | he cause of death?                     |
|  |                |   |  |                                |   |                                   | 1  | Yes 2∐No                         | 3 🗌 Prot                     | bably 4 XUnknown                       |
|  | ompleted       |   |  |                                |   |                                   | 24a. Was                                     |                                  | ). Were auto                 | opsy findings available                |
|  | E              |   |  |                                |   |                                   | perf   | ormed?<br>2.⊠No                  | death?<br>1 ☐ Yes            |  |
|  | Se C           | 25. Was case referred to medical  |  |                                |   | 26. Place o                       | f Death (Check only                          | -                                |                              |  |
|  | To B           | examiner?<br>1 ☐ Yes 2 ☑ No   | Hospital: 1 ☐ Inpatien   | t 2 ER/Outpa                   | tient 3 DOA Ott   | her: 4 Nurs                       | ing Home 5⊠ Res                              | dence 6 🗆 0                      | ther (Speci                  | fy)                                    |
|  | 2              | 27. Manner of Death   | 28a. Date of Injury<br>(Month, Day                                 | Year) 28b. Tim-                | e of 28c. Inju  | ry at                             | 28d. Describe                                | how injury occ                   | urred                        |  |
|  | atlo           | 1 ⊠Natural 5 ☐ Pending 2 ☐ Accident investigation   |  |                                |   | Yes 2□No                          | >  |                                  |                              |  |
|  | =              | 3 Suicide 6 Could not   |  | y · At home, farm,             | street, factory, office   |                                   |  | Street and Nur<br>wn, State)     | nber or Run                  | al Route Number,                       |
|  | Certification: | T Comicio   | building, etc.   | (Эрвспу)                       |   |                                   | City of To                                   | wii, State)                      |                              |  |
|  | Medical        | 29a. Certifier 1 🔀 Certifying F (Check only one)  | Physician: To the best of aminer: On the basis of and manner state | examination and/o              | eath occurred at the ti<br>r investigation, in my                     | ime, date and i<br>opinion, death | place, and due to the occurred at the time   | cause(s) and r<br>date and place | manner as s<br>e, and due t  | stated,<br>to the cause(s)             |
|  | ₹<br>E         | 29b. Signature and title of certifier   |  |                                | 29c. Licen  | se number                         | \$E.4034                                     | 29d. Date sign                   | ned (Month,                  | Day, Year)                             |
|  |                | > CARCO   | · av   | MA                             | DO  | 00 63                             | 1801   | 12/2                             | 3/2                          | MS.                                    |
|  |                | 20 Nama and addition  | annelstad and dis  | ath (tra= cc-) =               |   |                                   | 31   | , 4/4                            | 2/00                         |  |
|  |                | 30. Name and address of person who Edward McCarran  | completed cause of de  | atn (Item 23a) (Ty<br>Franklii | pe, Print)<br>n Square D  | rive S                            | Suite 2300                                   | Baltin                           | nore,                        | MD 21237                               |
| Į  | 404            | DA Data Mark (Mark David Mark)  | 00 0   | 1- 01                          |   |                                   |  |                                  |                              |  |
|  | tate<br>trar   | DEO 0 = -   | 005 Hegistra   | M A                            | books   |                                   |  |                                  |                              |  |
| ^  | /2001          | UEU 2 7 2   | UII) Distore   | 1 15 19                        |   |                                   |  |                                  |                              |  |
| / 1  | 12001          |   |  |                                |   |                                   |  |                                  |                              |  |

|                |  | - 02                  | 1 - For<br>State<br>Registrar   | State of Marylan   |  |  |   | lealth a<br>Death                       | ind M                   | ental Hy                           | giene<br>Reg. No.       | UUU  | 416   | 73                    |
|----------------|--|-----------------------|---|--|--|--|---|---|-------------------------|------------------------------------|-------------------------|--|---|-----------------------|
|                | Physici<br>/Medie  | al                    | Decedent's Name (First, Middle, Last)     MARK      4a. Facility Name (If not institution, give seconds)  |  |  | 4b Cib   |   | DOFF<br>Location o                      | DEC                     | 2. Date of De<br>Month<br>EMBER    | Day<br>23               | Y Yea<br>2001                                    | 5 11:4  |                       |
| <b>*</b>       | Examir<br>Funeral  | er                    | Saint Joseph M  5. Social Security Number   6. Sex  | edical Cent  |  |  | er 1 Year   |   | NSON                    | 8. Date of Bi                      | rth                     | Bal 9.8  | timore  Birthplace (State Country)                    | or Foreign            |
| 1              | Director   |                       | 184-12-1548  Usual Residence of Decedent  10a. State  10b. County   | 10c. City  | Yrs.                                   |  | Sayo  | 1100.0                                  |                         | 11/30/                             | 1922                    |  | NY 10d. Inside 0                                      | City Limits           |
|                | th the Mary<br>or 28a-f eho  | Director              | MD BALTIMOR  10e. Street and Number   | RE BAL   | TIMORE                                 |  | ip Code   |   |                         |                                    | 10g. Cit                | izen of What                                     |   | 2 No                  |
| 036            | ges 1 and 2 should be filed within 72 hours after death with the Maryland tof Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Exartic withing the putilied at   | d by Funeral Director | 7202 ROCKLAND HILL  11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced   | S DRIVE APT.  12. Was Decedent Ever in U. Armed Forces?  1 (NY 9s 2 D No If Yes, Give Year or Dates: | S. 13.                                 |  |   | ispanic Orig<br>in, Mexican<br>Specify: | gin? (Spe<br>, Puerto F | cify Yes or No<br>Rican, etc.)     | 0-                      | U.S.F.<br>14. Race - Ar<br>Black, WI<br>Specify: | nerican Indian,                                       |                       |
| 21215-0036     | d within 72 h<br>piene.<br>r than "natu  | Completed             | 15. Decedent's Edu<br>(Specify only highest grade<br>Elementary/Secondary (0-12)  |  | 16a. Dece<br>(Give<br>life.<br>TEAC)   | kind of w<br>DO NOT  | ual Occupi<br>rork done d<br>use retired              | during most                             | of working              | og.                                |                         | ind of Busines                                   | ,   |                       |
| Maryland ?     | 2 should be filed and Mental Hygic is marked other aumatic event, I  | To Be C               | 17. Father's Name (First, Middle, Last)   |  | AVIDOF                                 | F  |   | ANNA                                    |                         | (First, Middle                     | , Maiden                | Sumame)  | KINO  | à                     |
| Baltimore, Mar | permit. Pages 1 and 2 shr<br>Department of Health and<br>Important: If Item 27 is m<br>any injury or other traum<br>QDG9.  |                       | 19a. Informant's Name/Relationship (Ty MIRIAM DAVIDOFF  20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Funeral Service License  | WIFE 20b. P  | 7202<br>lace of Dispo<br>emetery, crei | ROCK Distion (Name of the Name | LAND<br>ame of<br>other place<br>IEMOR<br>and Address | HILLS  IAL 12  ss of Facility           | S DR.<br>2/26/<br>SOL   | APT.<br>'2005<br>LEVIN             | 505-<br>20c. Lo<br>REIS | STERSTO<br>& BROS                                | ON ZIP Code)  ONE MD OF TOWN, State  OWN, MD ONE INC. |                       |
| 8760,          | Physician /Medical Examiner supering physician and physician and supering s | dicai Examiner        | 23a. Part1. Enter the disease, or complishook, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | Due to (or as a consequence)   | uence of):<br>uence of):               | er the mo  | ode of dyin   | g, such as o                            | cardiac oi              | respiratory a                      | rrest,                  |  | Approxima<br>Interval Be<br>Onset and                 | tween                 |
| O. Box 6       | ne death certifi<br>the attending I<br>thed for use as   | Physician/Medical     | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown   | 3c. If yes, outcome of pregna 1□Live birth 2□Fetal 4□Pregnant at time of do 9□Unknown                | death 3                                | ]Ectopic   | pregnancy<br>specify)                                 |   |                         |                                    | :                       | 23d. Date of o                                   | delivery<br>Day                                       | Year                  |
| Д              | sign<br>d be   | by                    | Part II. Other significant conditions con   | ntributing to death but not resu   | ulting in the u                        | inderlying   | cause giv   | en in Part I.                           |                         |                                    |                         | 4  | to the cause of                                       |                       |
| Vital Records, | The law<br>ate has b<br>page 2 s   | Completed             |   |  |  |  |   |   |                         | 24a. Was<br>auto<br>perfe<br>1 Yes |                         | prior t<br>death                                 |   | available<br>cause of |
| of             | Attending Physician: Tr<br>r death.<br>ector: Atter this certificate<br>by the funeral director, pag   | ation; To Be          | 25. Was case referred to medical examiner?  1 Yes 2 No  27. Manner of Death  1 Natural 5 Pending 2 Accident investigation   | lospital: 1 A patient 2 2<br>28a. Date of Injury<br>(Month, Day Year)                                | ER/Outpatie<br>28b. Time o<br>Injury   |  | 28c. Injun<br>Wor                                     | er: 4 🗆 Nui                             | rsing Hon               | Check only<br>ne 5 Res             | idence                  | 6 □Other (S <sub>i</sub>                         | pecify)   |                       |
| Division       | tal or Attenders attenders attenders attenders at Director: ed in by the   | Certification:        | 3 Suicide 6 Could not be determined   | 28e. Place of Injury - At he building, etc. (Specify   | ()                                     |  |   |   |                         | City or To                         | wn, State               | P)   | Rural Route Nui                                       | nber,                 |
|                | To the Hospital or At within 24 hours after or To the Funeral Direct completely filled in by   | ledical               | 29a. Certifier 1 Certifying Physics (Check only one) 2 Medical Examination  | sician: To the best of my kno<br>ner: On the basis of examina<br>and manner stated.                  | wledge, deat<br>tion and/or in         | vestigatio   | n, in my o  | pinion, deat                            | d place, a              | nd due to the                      | date and                | d place, and d                                   | ue to the cause(                                      | s)                    |
| )              | To the within 2 To the complet   | Σ                     | 29b. Signature and title of centifier   |  |  |  | 9c. Licens<br>580                                     |   |                         |                                    |                         |  | nnth, Day, Year)                                      | 005                   |
| -              | ()   | ite                   | 30. Name and address of person who con CHRISTINE BOUTZ( 31. Date filed (Month, Day, Year)   | ALE, M. D. 70  | 501 0                                  | SLEF   |   | IVE 1                                   | 10W8                    | ON MA                              |                         |  | 1204  |                       |
| N. Carlot      | Regist   |                       | DEC 2 7 21  | 67   | K A                                    | north  | .0  |   |                         |                                    |                         |  |   |                       |

| Physic   | an                                    | 1. Decedent's Name (First, Middle, Las   | st)  | -  |                                       |                                       |  |                        |                  | 2. Date of Dea<br>Month  | Day   | Year   | 3. Time of Dear  |      |
|--|---------------------------------------|--|--|--|---------------------------------------|---------------------------------------|--|------------------------|------------------|--|---|--|--|------|
| /Medi  | cal                                   | A. Carilla Mana (Mana) and A.  | Robert   |  | nce E                                 |                                       |  | 1                      |                  | DECEMB   | 1   |  |  | М    |
| Exami  | ner                                   | 4a. Facility Name (If not institution, give<br>Baltimore Washing   |  |  | nter                                  |                                       | n Bu   | Location of            | Death            |  |   | County of Dea<br>.ne Aru   |  |      |
| Funeral  |                                       | 5. Social Security Number 6. S   | iex 7. Ag  | ge (in yrs. la   |                                       | If Under                              | 1 Year   | If Under 2             | 4 Hrs.           | 8. Date of Birth<br>(Month, Day  |   |  | thplace (State or For  | eign |
| Director   |                                       | 530-52-5781  | MM 2□F   | 50   | Yrs.                                  | Months                                | Days   | Hours                  | Min.             | Jan 21   | , Year)<br>, 19.  | 55 Ari   | izona  |      |
| 3  |                                       | Usual Residence of Decedent  10a. State 10b. County  |  | 10c Gity   | Town or Lo                            | cation                                |  |                        |                  |  |   |  | 10d. Inside City Lin   | nite |
| faho   | jo                                    | MD Anne Ari  | undo 1   |  | nton                                  |                                       |  |                        |                  |  |   |  | 1 \ Yes 2 □  |      |
| r 28a  | Director                              | 10e. Street and Number   | mueı   | _ Oue  | iicon                                 | 10f. Zip                              | Code   |                        |                  |  | 10g. Citiz  | en of What Co  | ountry?  |      |
| f Health and Mental Hygiene.<br>Item 27 is marked other then "naturel", or items 23a or 28a-f show<br>other traumatic event, the Medical Exantiner must be codified at | a D                                   | 537 Queen Anne Av  | venue .  |  |                                       | 21                                    | 113  |                        |                  |  | U.S.  | Α.   |  |      |
| tems<br>mr.m   | Funeral                               | 11. Marital Status   | 12. Was Decedent<br>Armed Forces?  |  | i. 13. \                              | Was Dece                              | dent of His  | spanic Orig            | in? (Spec        | cify Yes or No-<br>Rican, etc.)  | 1   | 4. Race - Ame<br>Black, Whit   |  |      |
| 0  | <b>by</b> Fu                          | 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☑ Divorced   | 1 XYes 2 If Yes, Give  | 1974-  |                                       | 1 🗆 Yes                               |  | Specify:               |                  |  |   | Specify: Wh:   |  |      |
| sture!   | ed b                                  | 15. Decedent's Ed  | Year or Dates:   | 1983   | 16a. Deced                            | dent's Usua                           | at Occupa  | tion                   |                  |  |   | d of Business  |  |      |
| ene.<br>then "ne<br>the Medis  | plet                                  | (Specify only highest gra  | de completed) College (1-4or   | 5.1)   | (Give                                 | kind of wo                            | rk done d<br>se retired)                           | uring most             | of workin        | g  | TOD. KIII   | a or basiness  | moustry  |      |
| Hygiene<br>other the   | Completed                             | 11   | College (1-401)  | J+)  | Comp                                  | uter                                  | Syst   | ems Ma                 | anage            | er   | Dep   | artmen   | t of Defe  | nse  |
| d oth  | Be                                    | 17. Father's Name (First, Middle, Last)  |  |  |                                       |                                       |  |                        |                  | (First, Middle,  | Maiden S  | Sumame)  |  |      |
| and Mental Hygiene. is marked other then aumatic event, tre M  | 70                                    | Robert Louis Edir  |  |  | 405 44-75                             |                                       | (2)  | Doris                  |                  |  |   |  |  |      |
| th an<br>27 is r<br>traur  |                                       | 19a. Informant's Name/Relationship (7)  Jane Galbreath /f  |  |  |                                       |                                       |  |                        |                  | Route Number   | . ,   |  | F /  |      |
| item 27  | 0                                     | 20a. Method of Disposition   |  |  | ice of Disno                          | sition (Nar                           | ne of  |                        |                  |  |   | ation · City or  |  |      |
| 0  |                                       | 1 ☐ Burial 2 ☑ Cremation 3 ☐<br>4 ☐ Donation 5 ☐ Other (Specify  |  |  | metery, crer<br>Arunde                |                                       |  |                        | ec 27            | , 2005   | 0de:  | nton, N  | Maryland   |      |
| orta<br>inju   |                                       | 21. Signature of Funeral Service Licen   |  | -1   |                                       |                                       |  |                        |                  | ome & C  |   |  |  |      |
| o d d d  |                                       | White me   | El-  | M0077  | 3 14                                  | 411 A                                 | nnapo  | olis l                 | Road             | , Odent  | on,   | Maryla:  | nd_21113   |      |
|  |                                       | 23a. Part1. Enter the dispase, or comp<br>shock, or heart fairure. List only   | one cause on each fi   | ine.   |                                       |                                       |  | , such as c            | ardiac or        | respiratory arr  | est,  |  | Approximate<br>interval Between  |      |
| nysician   |                                       | Immediate Cause (Fingle disease or condition resulting in death)   | SE   | PTI  | CEN                                   | MIA                                   | ,  |                        |                  |  |   |  | Onset and Death  | 5    |
| Medical xaminer  |                                       | resulting in dealth)   | Due to (or as  |  |                                       |                                       |  |                        |                  | /  |   |  | 1: 000   |      |
|  | er                                    | Sequentially list conditions,  | b. Due to (or as   |  |                                       |                                       |  |                        | 1                | 11/  | 1   |  | + 200  | 5    |
| dansit   | Examiner                              | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events  |  |  |                                       |                                       |  | N                      | ωV.              | UCAL   | EXAMINE   | 3  |  |      |
| sician and<br>burial-transit   | Еха                                   | resulting in death) Last   | Due to (or as  | a conseque   | ence of):                             |                                       |  | V                      | APPROV           | ED RI WET 10   |   |  |  |      |
| physici<br>the bu  | edical                                |  | . d.   |  |                                       |                                       | 0  | FICATION               | N1-              | ED BY MEDICAL  |   | e-0000 15455 g.d   |  |      |
| ding p   | Mec                                   | IF FEMALE:   | 00-16  |  | -11                                   |                                       |  |                        |                  |  |   |  |  | -    |
| attending p<br>for use as  | lan/Me                                | 23b. Was decedent pregnant in the past 12 months?  | 23c. If yes, outcome<br>1 ☐ Live birth<br>4 ☐ Pregnant at  | 2 Fetal d  | déath 3 □                             | Ectopic pr                            |  |                        |                  |  | 23  | d. Date of del   | ivery<br>Day Year  |      |
| o O  | Physici                               | 1 □ Yes 2 □ No<br>9 □ Unknown  | 9 Unknown  | THING OF GOE   | 30                                    | J Outer (Sp                           | ecily)   |                        |                  |  |   |  |  |      |
| y the  | by Pt                                 | Part II. Other significant conditions of   | ontributing to death b   | out not result   | ting in the ur                        | nderlying c                           | ause give  | n in Part I.           |                  | 23e. Did tol   | bacco us  | e contribute to  | the cause of death?  |      |
| ned by the<br>e detached   |                                       | RIADRIDI   | EGIA d   | ue to  | cerv                                  | ıcal                                  | frac   | ture                   |                  | 1 □ Y  | es 2 🗆  | No 3□Pr  | obably 4 Onkno   | wn   |
| on signed by the   | ed b                                  | - CONDRIF  |  |  |                                       |                                       |  |                        |                  |  |   |  |  | bie  |
| as been signed by the<br>2 should be detached  | pleted b                              | WIND KIT   |  |  |                                       |                                       |  |                        |                  | 24a. Was a   |   | 24b. Were au   | topsy findings availa  | OI   |
| ate has been signed<br>page 2 should be de   | Completed b                           | C WITTER S   |  |  |                                       |                                       |  |                        |                  | autops<br>perforr  | med2  | prior to death?  | completion of cause  |      |
|  | Be Completed b                        | 25. Was case referred to medical examiner?   |  |  |                                       |                                       |  | 26. Place o            | of Death         | autops<br>perforr  | med2<br>2 No  | prior to d   | completion of cause  |      |
|  | To Be Completed                       | 25. Was case referred to medical examiner?   | Hospital:  |  | R/Outpatien                           |                                       |  | r: 4 🗆 Nurs            | sing Hom         | autops perform 1 Yes 2 Check only on e 5 Reside  | med?<br>2 No<br>ne<br>ence 6  | prior to death? 1 Yes  | 2 No   |      |
| After this certifica<br>uneral director, p   | To Be Completed                       | 25. Was case referred to medical examiner? 1 X Yes 2 D No 27. Manner of Death 1 C Natural 5 □ Pending  | 28a. Date of Inju<br>(Month, Da  | y Year) 2  | 28b. Time of Injury                   | 2                                     | 8c. Injury<br>Work                                 | r: 4 □ Nurs<br>at<br>? | sing Hom         | autops perform 1 Yes :  Check only on e 5 Reside   | med2<br>2 No<br>2 No<br>eel<br>ence 6   | prior to death? 1  Yes   | 2 No   |      |
| ath.<br>r: After this certifica<br>te funeral director, p  | To Be Completed                       | 25. Was case referred to medical examiner?  1 XYes 2 100  27. Manner of Death  1 Actual 5 Pending investigation 2 Accident investigation 3 Suicide 6 Could not be  | 28a. Date of Inju<br>(Month, Da<br>09/04/  | iry<br>19 Year)<br>1 <b>990</b>  | 28b. Time of Injury <b>4p</b>         | M 2                                   | 8c. Injury<br>Work<br>1 🗆 Y                        | r: 4 🗆 Nurs            | sing Hom         | autops perform  1 Yes  Check only one  5 Reside  8d. Describe ho   | med?<br>2 No<br>ee<br>ence 6<br>ow injury   | prior to c death? 1  Yes  Other (Special Conferment)   | completion of cause  2 ☐ No  cify)   |      |
| ath.<br>r: After this certifica<br>te funeral director, p  | To Be Completed                       | 25. Was case referred to medical examiner?  1 XYes 2 D No  27. Manner of Death  1 D Natural 5 Pending investigation  | 28a. Date of Inju (Month, Da O9/O4/ 28e. Place of Inju building, et  | iry<br>19 Year)<br>1 <b>990</b>  | 28b. Time of Injury <b>4p</b>         | M 2                                   | 8c. Injury<br>Work<br>1 🗆 Y                        | r: 4 □ Nurs<br>at<br>? | 28<br>o <b>1</b> | autops perform 1 Yes : Check only on e 5 Reside 8d. Describe he Fell of: City or Town  | med? 2 No 2 No 20 | prior to c death? 1 ☐ Yes  ☐ Other (Spec occurred  Oof  Number or Bu Pasade  | city)  |      |
| ath.<br>r: After this certifica<br>te funeral director, p  | Certification: To Be Completed        | 25. Was case referred to medical examiner?  1  Yes   | 28a. Date of Inju (Month, Da 09/04/ 28e. Place of Inju building, et at   | iny Year) 1990 iny - At hom c. (Specify) house                                 | 28b. Time of Injury 4p                | M 2                                   | 8c. Injury Work  1 Y                               | at ? es 2 N            | o 1              | autops perform 1 Yes :    Check only one   5   | med2 2 1 No  pel  pence 6 pw infury  freet and n, State)  hatta   | prior to death? 1 Yes  Other (Special Control of Butter)  Number or Butter)  Pasade  an Beach  | city)  aral Route Number, ena, MD  stated  |      |
| ath.<br>r: After this certifica<br>te funeral director, p  | edical Certification: To Be Completed | 25. Was case referred to medical examiner?  1 X Yes 2 100  27. Manner of Death  1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1  | 28a. Date of Inju<br>(Month, Da<br>09/04/<br>28e. Place of Inj<br>building, et   | 1990 iury - At hom ic. (Specify) house of my knowl if examinatio               | 28b. Time of Injury 4p                | M 2                                   | 8c. Injury Work  1 Y                               | at ? es 2 N            | o 1              | autops perform 1 Yes :    Check only one   5   | med2 2 1 No  pel  pence 6 pw infury  freet and n, State)  hatta   | prior to death? 1 Yes  Other (Special Control of Butter)  Number or Butter)  Pasade  an Beach  | city)  aral Route Number, ena, MD  stated  |      |
| After this certifica<br>uneral director, p   | Certification: To Be Completed        | 25. Was case referred to medical examiner?  1 X Yes 2 No.  27. Manner of Death  1 Accident 5 Pending investigation 3 Suicide 6 Could not be determined  25a. Certifier 1 Certifying Phrocheok only 2 Medical Example           | 28a. Date of Inju (Month, Da O9/04/ 28e. Place of Injuiding, et at visiting. On the basis of and manner sta  | iny y Year) 1990 iury - At hom c. (Specify) house of my knowl of examination   | 28b. Time of Injury 4p                | M eet, factory                        | 8c. Injury Work 1 Y , office                       | at ? es 200 N          | o 1 place, ar    | autops perform 1 Yes 2  Check only on e 5 Reside 3d. Describe he Fell of City or Town 710 Powl at the time, d                                      | med 2 2 1 No les 2 2 2 1 No les 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2   | prior to death? 1 Yes  Other (Special Pasade an Beach and Manufer of Bull Pasade and Manufer and Manuf | city)  aral Route Number,  and R |      |
| ath.<br>r: After this certifica<br>te funeral director, p  | edical Certification: To Be Completed | 25. Was case referred to medical examiner?  1 X Yes 2 100  27. Manner of Death  1 Actural 2 Accident investigation 3 Suicide 6 Could not be determined  29a. Certifier (Check only one)  29b. Signature and title of certifier | 28a. Date of Inju (Month, Date of Inju (Month, Date of Inju (Month, Date of Inju Injury) 28e. Place of Injury) 3 injury 29 inj | iny Year) 1990  ury - At hom c. (Specify) house of my knowl f examinatic ated. | 28b. Time of Injury 4p ne, farm, stre | M eet, factory coccurred vestigation. | 8c. Injury Work 1 Y  office  at the time, in my op | es 200 N               | o 1 28           | autops perform 1 Yes : Check only on e 5 Reside Bd. Describe he Fell of: Bf. Location (St. City or Town 710 Pow) and due to the cid at the time, d | med 2 new med 2 new infury  freet and n. State)  hatta ause(s) a ate and p  9d. Date  | Dother (Special Control of Contro | completion of cause  2 No  cify)  cify)  cral Route Number,  ch Rd.  stated.  to the cause(s)  n, Day, Year)  CR. 26, 2  | _    |
| ath.<br>r: After this certifica<br>te funeral director, p  | edical Certification: To Be Completed | 25. Was case referred to medical examiner?  1 X Yes 2 100  27. Manner of Death  1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1  | 28a. Date of Inju (Month, Date of Inju (Month, Date of Inju (Month, Date of Inju Injury) 28e. Place of Injury) 3 injury 29 inj | iny Year) 1990  ury - At hom c. (Specify) house of my knowl f examinatic ated. | 28b. Time of Injury 4p ne, farm, stre | M eet, factory coccurred vestigation. | 8c. Injury Work 1 Y  office  at the time, in my op | es 200 N               | o 1 28           | autops perform 1 Yes : Check only on e 5 Reside Bd. Describe he Fell of: Bf. Location (St. City or Town 710 Pow) and due to the cid at the time, d | med 2 new med 2 new infury  freet and n. State)  hatta ause(s) a ate and p  9d. Date  | Dother (Special Control of Contro | completion of cause  2 No  cify)  cify)  cral Route Number,  ch Rd.  stated.  to the cause(s)  n, Day, Year)  CR. 26, 2  | _    |

EDINGS ROBERT

|                     |  |                  | 1 - State<br>Registrar  | State of Maryla   |                                    |                           |                          | lealth a<br>Death            | nd Me                   |                                   | giene<br>Reg. No.        | 05                                | 41675  |
|---------------------|--|------------------|---|---|------------------------------------|---------------------------|--------------------------|------------------------------|-------------------------|-----------------------------------|--------------------------|-----------------------------------|--|
|                     |  |                  | Decedent's Name (First, Middle, Last)   |   |                                    |                           |                          |                              | 2                       | 2. Date of Dea                    | ith                      |                                   | 3. Time of Death                                   |
|                     | Physici<br>/Medio  |                  | Jessie  | В.  |                                    | Edw                       | ards                     |                              | I                       | Decembe                           | er 24                    | . 2005                            | 10:05 pм   |
|                     | Examir   |                  | 4a. Facility Name (If not institution, give s   |   |                                    |                           |                          | Location of                  | Death                   |                                   | 4c. C                    | ounty of Death                    | 1  |
|                     |  |                  | Harbor Hospital Cen   |   |                                    |                           | altin                    |                              |                         |                                   |                          | NA                                |  |
|                     | Funeral  |                  | 5. Social Security Number 6. Sex 216-52-4600 1□   | M OF XE   | . last birthday)<br>Yrs.           | Months                    | Days                     | If Under 2<br>Hours          | Min.                    | B. Date of Birtl<br>(Month, Da)   | Year)                    | 9. Birth                          | iplace (State or Foreign<br>intry)                 |
|                     | Director   |                  | Usual Residence of Decedent   | 55  |                                    |                           |                          |                              |                         | 8–25-                             | -50                      |                                   | S.C.   |
|                     | yland  |                  | 10a. State 10b. County  | 10c. C  | ity, Town or Lo                    | ocation                   |                          |                              |                         |                                   |                          |                                   | 10d. Inside City Limits                            |
|                     | Mar-   | 햦                | Md. NA  |   | Balt                               | imor                      | e                        |                              |                         |                                   |                          |                                   | Y∏Yes 2 ☐ No                                       |
|                     | or 28  | ire              | 10e. Street and Number  | _   |                                    | 10f. Zi                   | ip Code                  |                              |                         |                                   | 10g. Citize              | n of What Cou                     | intry?   |
|                     | ath w  | Ta I             | 2701 Spellman Ro  | ad Apt.   | B-2                                |                           | 2.                       | 1225                         |                         |                                   | USA                      |                                   |  |
|                     | 72 hours atter death with the Maryland<br>natural; or Iteme 23a or 28a-f ehow<br>dical Examinat must be notified at                              | Funeral Director |   | <ol><li>Was Decedent Ever in I<br/>Armed Forces?</li></ol>                              | U.S. 13.                           | Was Dece<br>If Yes, spe   | edent of H<br>ecify Cuba | ispanic Origi<br>n, Mexican, | in? (Speci<br>Puerto Ri | ify Yes or No-<br>ican, etc.)     | 14                       | I. Race - Ameri<br>Black, White,  |  |
| 36                  | rs all   | by F             | 1 Never Married 2 Married 3 Widowed 4 Divorced  | 1 ☐ Yes 2 ☑ No<br>If Yes, Give ⚠<br>Year or Dates:                                      |                                    | 1 🗌 Yes                   | 2\(\int \n^0             | Specify:                     |                         |                                   | s                        | pecify: B1                        | lack   |
| Ş                   | 2 hou  | ed               | 15. Decedent's Educ   | ation   | 16a. Dece                          | dent's Usu                | ual Occup                | ation                        |                         |                                   | 16b. Kind                | of Business/Ir                    |  |
| 215                 | S E  | piet             | (Specify only highest grade<br>Elementary/Secondary (0-12)  | completed) College (1-4or 5+)   | (Give                              | kind of w                 |                          | during most                  | of working              | 7                                 |                          |                                   |  |
| 21                  | ad with<br>giene.  | Completed        | 12th grade  |   | Pac                                | ker                       |                          |                              |                         |                                   | Ess                      | kay                               |  |
| p                   | be filed<br>htal Hygi<br>ed other<br>event, I  | Be (             | 17. Father's Name (First, Middle, Last)   |   |                                    |                           | :                        | 18. Mother                   | 's Name (               | First, Middle,                    | Maiden S                 | umame)                            |  |
| Z<br>Za             | should that Ment and Ment should the marked umatic a   | 2                | Parker  |   | Edward                             |                           |                          |                              | sie                     |                                   |                          |                                   | nders  |
| Maryland 21215-0036 | 01 00 00 00  |                  | 19a. Informant's Name/Relationship (Typ   |   |                                    | _                         |                          |                              |                         |                                   |                          | Town, State, Zip                  |  |
|                     | Health<br>tem 27<br>other tra  |                  | Carla Skinner 20a. Method of Disposition  | Daughter 20b.   | Pface of Dispo                     |                           |                          | Road,                        | Bali                    | timore,                           |                          | 21225<br>ation - City or To       |  |
| D<br>D              | Pages<br>nent of<br>nt: if it<br>iry or o  |                  | 1 ☐ Burial 2 【Cremation 3 ☐ Re  |   | cemetery, crei                     | natory or                 | other plac               |                              | 12-29                   |                                   |                          |                                   |  |
| Baltimore,          |  |                  | 4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Funeral Service Ligense  |   | Green                              |                           |                          | s of Facility                |                         |                                   |                          | imore,                            |  |
| ñ                   | permit. Departr import eny inj   |                  | Jahrille  | Cork  | /                                  |                           |                          | East                         |                         | 101 E.                            |                          | ore, Mo<br>h Ave                  | 1. 21202   |
| 1                   | Physician<br>/Medical<br>Examiner  |                  | 23a. Part1. Enter the disease, or complic shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)           | ations that caused the deal a cause on each line.  #UTRACE(  Due to (or as a conse      | REBEL                              |                           |                          |                              |                         |                                   | est,                     |                                   | Approximate<br>Interval Between<br>Onset and Death |
| 8760,               | icate be executed<br>physicien and<br>s the burial-transit   | dicai Examiner   | S. uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | Due to (or as a conse   |                                    |                           |                          |                              |                         |                                   |                          |                                   |  |
|                     | law requires thet the death certificat<br>es been signed by the ettending phy<br>2 should be detached for use as th                              | Physician/Medio  | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yas 2 ☐ No   | c. If yes, outcome of pregn<br>1 Live birth 2 Fet<br>4 Pregnant at time of<br>9 Unknown | al death 3                         | ]Ectopic p<br>] Other (s, |                          |                              |                         |                                   | 230                      | d. Date of delive                 | ery<br>Day Year                                    |
| rds, F              | w requires the<br>been signed<br>should be del   | þ                | Part II. Other significant conditions conf  | nbuting to death but not re   | sulting in the u                   | nderlying                 | cause give               | n in Part I.                 |                         | 23e. Did to                       | -                        |                                   | he cause of death?                                 |
| Vital Records,      | 0 - 0  | Completed        |   |   |                                    |                           | -                        |                              |                         | 24a. Was a<br>autops<br>perform   | V                        | prior to co                       | opsy findings available impletion of cause of      |
| ïta                 | ysician: Th<br>is certiticate<br>director, pag   | Be               | 25. Was case referred to medical examiner?  |   |                                    |                           |                          | 26. Place o                  | of Death (              | Check only on                     |                          |                                   |  |
|                     | 9 w =  | 2                | 1⊠Yes 2□No  |   | ER/Outpatien                       |                           |                          | 4 🗀 14012                    | sing Home               | 5 🗌 Reside                        | ence 6 [                 | Other (Specif                     | (y)  |
| u u                 | ing P  | ë.               | 27. Manner of Death 1 ☑Natural 5 ☐ Pending  | 28a. Date of Injury<br>(Month, Day Year)  | 28b. Time of<br>Injury             |                           | 28c. Injury<br>Work      |                              |                         | d. Describe ho                    | ow injury o              | occurred                          |  |
| <u>si</u>           | Attending r death. ector: After by the fune  | icat             | 2 Accident investigation 3 Suicide 6 Could not be   | 00-01   |                                    | М                         |                          | ∕es 2 □ No                   |                         | ( ) ( )                           |                          |                                   |  |
| Division of         | To the Hospital or Attending Phy<br>within 24 hours atten death.<br>To the Funeral Director: After thi<br>completely filled in by the funeral or | Certification:   | 4 Homicide determined   | 28e. Place of Injury - At h<br>building, etc. (Speci                                    | ify)<br>                           |                           |                          |                              |                         | City or Towi                      | n, State)                |                                   | al Route Number,                                   |
|                     | To the Hospital or within 24 hours afte To the Funeral Director Completely filled in the   | edical           | 29a. Certifier 1 Certifying Physic Check only one)  | cian: To the best of my kn<br>er: On the basis of examination<br>and manner stated.     | owledge, death<br>ation and/or inv | occurred<br>vestigation   | at the tim               | e, date and<br>inion, death  | place, and<br>occurred  | d due to the ca<br>at the time, d | ause(s) ar<br>ate and pl | nd manner as s<br>ace, and due to | stated.<br>the cause(s)                            |
|                     | To the To the Comp   | M                | 29b. Signature and title of certifier   |   |                                    | 29                        | c. License               |                              |                         |                                   |                          | signed (Month,                    |  |
|                     | 1  |                  | Munite 1/2  | e Shel 1  | 41)                                |                           | OCM                      | E                            |                         |                                   | Decen                    | mber 25                           | , 2005   |
|                     | 1  |                  | 30. Name and address of person who con  | pleted cause of death (Ite  | m 23a) (Type,                      | Print) 1]                 | ll Pe                    | nn Sti                       | reet                    | Balti                             | more                     | , Maryl                           | and 21201  |
|                     |  |                  | MAKGAMAN A.KOG  | LEW   |                                    |                           |                          |                              |                         |                                   |                          |                                   |  |
|                     | Sta<br>Registr   |                  | 31. Date filed (Month, Day, Year)  DEC 2. 7 2005  | 32. Registrar's Sign  | ature                              | 00 n                      |                          |                              |                         |                                   |                          |                                   |  |

| FEMALE:  |        |   |          | rica  |                                      |                                       | etmost of Health and   | _   |   |       |
|--|--------|---|----------|---|--------------------------------------|---------------------------------------|--|---|---|-------|
| 1. Descender Paris Paris Medition Last)   2. Description of the challenge of the challeng   |        |   |          | 1 - State<br>Begistrar  | State of Mai                         |                                       |  |   | 2005 6 6 76   | )     |
| Examinor  Famoral Director  Fa |        |   |          |   | , Last)                              | 1                                     | , C  | 2. Date of Dea                            | ath 3. Time of Dea  | th    |
| Company of the property of t   |        |   |          | NORMO   | an Lesli                             | e Coke                                | 15. JA.  |   |   | 1 м   |
| Suppose programment    |        |   |          | 4a. Facility Name (If not institution                                       | 41 .                                 | 11                                    | 1 1 .  |   | 2   |       |
| Directors    Same   Sam |        |   |          | 5. Social Security Number   |                                      | TOMO                                  |  |   |   |       |
| Description of the control of the    | П      |   |          | 213-03-4505   | " 1 M 2 □ F                          | 01                                    |  | . (Month, Day                             | (, Year) Country)   | reign |
| The part of the pa |        | pu *                                    |          |   | 1.                                   | Inc. City Town as I                   |  |   | ,   |       |
| The part of the pa |        | Aaryla<br>f show                        | ō        | MAN BALL  | Timo 0 =                             | R. City, Town of Lo                   | 4  |   |   |       |
| The part of the pa |        | 28e-                                    | rect     | 10e. Street and Number  | MINIORE                              |                                       |  | 1   |   |       |
| The part of the pa |        | th with                                 | al D     | 9902 Var  | J Tassel                             | Lane                                  | 21220  |   | NSA.  |       |
| The part of the pa |        | tems                                    | uner     | 1.  | 12. Was Decedent Ev<br>Armed Forces? | er in U.S. 13.                        | Was Decedent of Hispanic Origin? (If Yes, specify Cuban, Mexican, Puer           | Specify Yes or No-<br>no Rican, etc.)     | 14. Race - American Indian,<br>Black, White, etc.                       |       |
| The part of the pa | 36     | rs afte                                 | by Fi    | , -   | ed 1 Tyes 2 No<br>If Yes, Give       |                                       | 1.2  |   |   |       |
| The part of the pa | 8      | 2 hou                                   | ted      | 15. Decedent  | 's Education                         | 16a. Dece                             | dent's Usual Occupation  |   | 16b. Kind of Business/Industry  |       |
| The part of the pa | 2      | thin 7<br>e.<br>Man n                   | nple     |   |                                      | life.                                 | DO NOT use retired)  | orking                                    |   |       |
| The part of the pa |        | led wi                                  | Con      |   |                                      | Telle                                 | -  |   |   |       |
| Physician Medical Examiner  Physician Medical Examiner  The physician Medical Examiner Medical Examiner  The physician Medical Examiner Medical Examiner Medical Examiner  The physician Medical Examiner Medical Examiner Medical Examiner Medical Examiner Medical Examiner Medical Examiner  The physician Medical Examiner  | anc    | d be findal Head of                     | ) Be     | 17. Father's Name (First, Middle, I   | Cokols                               |                                       | 18 Mother's Na   | me (First, Middle,                        | Maiden Sumame)  |       |
| Physician Medical Examiner  Physician Medical Examiner  The physician Medical Examiner Medical Examiner  The physician Medical Examiner Medical Examiner Medical Examiner  The physician Medical Examiner Medical Examiner Medical Examiner Medical Examiner Medical Examiner Medical Examiner  The physician Medical Examiner  | 37     | shoulk<br>nd Me<br>mark<br>imatik       | ĭ        | 19a Informant's Name/Relationsh   | nip (Type, Print)                    | 19b. Maili                            | ng Address (Street and Number or R   | ural Route Number                         | City or Town, State, Zip Code)  |       |
| Physician Medical Examiner  Physician Medical Examiner  The physician Medical Examiner Medical Examiner  The physician Medical Examiner Medical Examiner Medical Examiner  The physician Medical Examiner Medical Examiner Medical Examiner Medical Examiner Medical Examiner Medical Examiner  The physician Medical Examiner  |        | alth a alth a 27 is                     |          | Connie Ecke   | 15-wife                              | 9900                                  | 2 Un Tassel L  | ane BA                                    | ETIMORE MO 212  | 71    |
| Physician Medical Examiner  Physician Medical Examiner  The physician Medical Examiner Medical Examiner  The physician Medical Examiner Medical Examiner Medical Examiner  The physician Medical Examiner Medical Examiner Medical Examiner Medical Examiner Medical Examiner Medical Examiner  The physician Medical Examiner  | ore    | of He<br>of He<br>if item<br>ir oth     |          |   | 3 DRemoval from State                | 20b. Place of Dispo<br>cemetery, crei | osition (Name of matory or other place)  | Date                                      | 20c. Location - City or Town, State                                     |       |
| Physician Medical Examiner  Physician Medical Examiner  The physician Medical Examiner Medical Examiner  The physician Medical Examiner Medical Examiner Medical Examiner  The physician Medical Examiner Medical Examiner Medical Examiner Medical Examiner Medical Examiner Medical Examiner  The physician Medical Examiner  | Ě      | Pag<br>tment<br>tent: I                 |          | `4 Donation 5 Dother (Sc  | pecify)                              | Gardens                               | of FaithConolly  | 12-28-0                                   | DALTIMORE MY  | 0,_   |
| Physician Medical Examiner  Physician Medical Examiner  The physician Medical Examiner Medical Examiner  The physician Medical Examiner Medical Examiner Medical Examiner  The physician Medical Examiner Medical Examiner Medical Examiner Medical Examiner Medical Examiner Medical Examiner  The physician Medical Examiner  | Bai    | Depar<br>Depar<br>mpor<br>eny in        |          | 21. Signature of Funeral Service t  | icensee                              |                                       | 2-525 VOK  | KRD:5                                     | TIMBRIUM MD2109   | 3     |
| Physician Medical Examiner Consideration in death)  The properties of the properties |        |   | -        | 23a. Part1. Enter the disease, or   | complications that caused the        |                                       |  |   |   | ACT   |
| Sequentially let conditions, fairly, letting in death) Last    Sequentially let conditions, fairly, letting in death) Last   Sequentially let conditions, fairly, letting in death) Last   Sequentially let conditions, fairly, letting in death) Last   Sequentially let conditions, fairly, letting in death) Last   Sequentially let conditions, fairly, letting in death) Last   Sequentially let conditions, fairly, letting in death) Last   Sequentially letting in death Last   Sequentially letting in death) Last   Sequentially let |        | Physician                               |          | Immediate Cause (Final  | only one cause onleach line.         |                                       |  | ,   | Interval Between<br>Onset and Death                                     | 1     |
| Sequentially list conditions of any interest of the past ize months?    Sequentially list conditions   Due to (or us a confequence of):  |        | /Medical                                |          | resulting in death)   | Due to (or as a                      | consequence of):                      | Mynraum  |   |   |       |
| Service and property   Service   S   |        | Examiner                                | ,        | Sequentially list conditions.   | ا ا                                  | Leson                                 | e Dechm  | 2   |   |       |
| Second   S   |        | ed sit                                  | iner     | rany, leading to immediate cause. Enter Underlying Cause (Disease or injury | Due to (or as a c                    | equence of):                          |  |   |   |       |
| Second   S   |        | al-trar                                 | xan      | that initiated events   | c. Due to (or as a                   | consequence of):                      |  |   | 171   |       |
| FFEMALE: 23b. Was deeded pregnant in the past 12 months?   1   1   1   1   1   1   1   1   1   | 760    | s be e                                  |          |   | d Cen                                | bouver                                | mlan Acci  | clent                                     |   |       |
| 1   Yes 2   No 3   Probably 4   Unknown  | 89     | rtificat<br>ng phy<br>as th             |          | IS ESTABLE  |                                      |                                       |  |   |   |       |
| 1   Yes 2   No 3   Probably 4   Unknown  | gox    | ath cei<br>Itendii<br>or use            | an/N     | 23b. Was decedent pregnant  |                                      |                                       | Ectopic pregnancy  |   |   |       |
| 1   Yes 2   No 3   Probably 4   Unknown  | 0      | he dea<br>the a                         | ysic     | 1 ☐ Yes 2 ☐ No  |                                      | ne of death 5                         | Other (specify)  |   | Month Day feat  |       |
| 1   Yes 2   No 3   Probably 4   Unknown  | ٣.     | that the                                | y Ph     | Part II. Other significant conditio   | ns contributing to death but         | not resulting in the u                | nderlying cause given in Part I.   | 23e. Did tot                              | bacco use contribute to the cause of death?                             | ,     |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SHDALLS A HAPHMIMD \$2 ( N) FUTAN ST Fina to 30 ( BALTIM DUE MI) 2130   | rds    | quires<br>in sign                       | q pe     | Demen   | ta                                   |                                       |  | 1 □ Ye                                    | es 2 No 3 Probably 4 Unkno  | own   |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SHDALLS A HAPHMIMD \$2 ( N) FUTAN ST Fina to 30 ( BALTIM DUE MI) 2130   | 000    | aw re                                   | plete    |   |                                      |                                       |  |   | n 24b. Were autopsy findings availa                                     | ıble  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SHDALLS A HAPHMIMD \$2 ( N) FUTAW ST Finate 30 ( BALTIM DIE MI) 2130  | m<br>m | The Tate has page                       | Som      |   |                                      |                                       |  | perform                                   | med? _ death?   | or    |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SHDALLS A HAPHMIMD \$2 ( N) FUTAN ST Fina to 30 ( BALTIM DUE MI) 2130   | /ita   | icien:<br>sartific<br>ector,            | Be       |   | Hoppital                             |                                       | 0.1  |   |   |       |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SHDALLS A HAPHMIMD \$2 ( N) FUTAN ST Fina to 30 ( BALTIM DUE MI) 2130   | o      | Physic<br>this cral dir                 | <b>-</b> |   | 1 Inpatient                          |                                       | IT 3[] DOA   4 [9 Nursing I  |   |   |       |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SHDALLS A HAPHMIMD \$2 ( N) FUTAN ST Fina to 30 ( BALTIM DUE MI) 2130   | o      | th.<br>: After                          | ition    | 1 ☑Natural 5 ☐ Pending  | (Month, Day Y                        |                                       | Work?  | 200. Describe no                          | ow injury occurred  |       |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SHDALLS A HAPHMIMD \$2 ( N) FUTAN ST Fina to 30 ( BALTIM DUE MI) 2130   | Visi   | Atter<br>er dea<br>ector<br>by the      | tifice   | 3 ☐ Suicide 6 ☐ Could n   | ned 286. Place of injury             | - At home, farm, str                  | eet, factory, office   |   |   |       |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SHDALLS A HAPHMIMD \$2 ( N) FUTAN ST Fina to 30 ( BALTIM DUE MI) 2130   | ā      | ital or<br>rs afte<br>rel Dir<br>led in | Cert     |   |                                      |                                       |  |   |   |       |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SHDALLS A HAPHMIMD \$2 ( N) FUTAN ST Fina to 30 ( BALTIM DUE MI) 2130   |        | Hosp<br>4 hou<br>Fune<br>tely fil       | ical     | Check only 2 Medical E  | xaminer: On the basis of ex          | camination and/or in                  | n occurred at the time, date and place<br>vestigation, in my opinion, death occi | e, and due to the caurred at the time, da | ause(s) and manner as stated.<br>ate and place, and due to the cause(s) |       |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SHDALLS A HAPHMIMD \$2 ( N) FUTAN ST Fina to 30 ( BALTIM DUE MI) 2130   |        | o the<br>ithin 2<br>o the<br>mplet      | Med      | one)  | and manner state                     | · · · · · · · · · · · · · · · · · · · |  |   |   |       |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  SHDAUS A HAPHMIMD & (Item 23a) (Type, Print)   | )      | F ≯ F ŏ                                 |          | ) sec   | BN                                   | MID                                   |  |   | - · · · · · · · · · · · · · · · · · · ·                                 |       |
| SHOALLS A. HASHMIMD 821 N. EVITAW ST STUTE 30 & BALTIMONE MID 2120  State Registrar  31. Date filed (Moppin Day, Year) 7 2005  32. degistrar's Signature   |        | 9                                       |          |   | who completed cause of dea           |                                       | Print)   |   |   |       |
| State Registrar  31. Date filed (Moort Day, Year)  7 2005  |        | D                                       |          |   | 1 /                                  | 821 r                                 | V. EUTAWST &   | inte 30 s                                 | BALTIMONE MD.   | 2120  |
|  |        |   | te<br>ar | 31. Date filed (Month Day, Year)  | 2005 32 legistrar's                  | Signature                             | ander  |   |   |       |

NORMAN ECKEIS

|  |   |                | ricasc  | State of Mandan  |   |                      |   | -   | •                                    | •  |  |
|--|---|----------------|---|--|---|----------------------|---|---|--------------------------------------|--|--|
|  |   |                | 1 _ State   | State of Marylar   |   | ertificate of        |   | Mental Hy   | glene n n 5                          | 41677                                    |  |
|  |   |                | Registrar  1. Decedent's Name (First, Middle, La  | eet)   |   | eruncate of          | Dealii  | 2. Date of De.  | Reg. No.                             | 2 First of Posts                         |  |
|  | Physici<br>/Medic<br>Examin   | an             |   |  |   |                      |   | Month   | Day Yes                              |  |  |
|  |   |                | Josephine There  4a. Facility Name (# not institution, give   |  |   | 4h City Town         | or Location of Deat   | Decembe   | er 22 200                            |  |  |
|  |   | ıer            |   |  |   |                      | Harford County  |   |                                      |  |  |
|  |   | -              |   | Sex 7. Age (In yrs.  | last birthday   | Belcam               | If Under 24 Hrs   |   | th 9.1                               | Birthplace (State or Foreign<br>Country) |  |
|  | Director  |                | 070-12-1341   | 1□ M 27√F 36   | Yrs.  | Months Days          | Hours Min.  | Oct. 22   | , Year)<br>1919   N                  | ew York                                  |  |
| 7  |   |                | Usual Residence of Decedent   |  | -   |                      |   |   |                                      |  |  |
| char   | show  | -              | 10a. State 10b. County  |  | ty, Town or I   | _ocation             |   |   |                                      | 10d. Inside City Limits                  |  |
| N 09   | 8a-f  | Director       |   | d County   Jo  | рра   |                      |   |   |                                      | 1 ☐ Yes 2 ☐ No                           |  |
| dis  | Mortal Hygione.  Mantal Hygione.  marked other than "natural", or flems 23s or 28s-f show matic event, the Medical Examiner must be notified at   |                | 10e. Street and Number  |  |   | 10f. Zip Code        |   |   | 10g. Citizen of What                 | -  |  |
| q  |   | Funeral        | 418 Latimer Roa   | 12. Was Decedent Ever in U   | S 13  | 2108.                |   |   | Jnited Sta                           | tes<br>merican Indian,                   |  |
| 200  |   | E.             | 1 ☐ Never Married 2 ☐ Married   | Armed Forces?  | rces?   |                      | Hispanic Origin? (S<br>ban, Mexican, Puer                           | to Rican, etc.)   | Black, W                             |  |  |
|  | o',la   | by             | 3.□Widowed 4 □ Divorced   | 1 ☐ Yes 2 ☐ No<br>If Yes, Give<br>Year or Dates:                               |   | 1 ☐ Yes No Specify:  |   |   | Specify: W                           | hite                                     |  |
| 5 3  | ical  | Completed      | 15. Decedent's Education 16a. Decedent (Specify only highest grade completed) (Give kinc.   |  |   | edent's Usual Occu   | ent's Usual Occupation 1 kind of work done during most of working   |   |                                      | 6b. Kind of Business/Industry            |  |
| <b>7</b>                                     | e.<br>Med   | ple            | Elementary/Secondary (0-12)   | College (1-4or 5+)   | 4or 5+) life. DO NOT use retired)   |                      |   | rking   |                                      | and the second second                    |  |
| <b>'</b>                                     | Hygiene.<br>other than<br>ent, the M  | Son            |   | 4  | Teac  | cher                 |   |   | Public                               | School                                   |  |
| מנומ   | h and Mental<br>h and Mental<br>7 is markad c<br>traumatic eve  | Be             |   |  |   |                      |   | First, Middle, Maiden Sumame)   |                                      |  |  |
| 2 2  |   | ၉              |   |  |   |                      |   | red McGillic  |                                      |  |  |
| -  |   |                | 19a. Informant's Name/Relationship  |  |   |                      |   |   | er, City or Town, State              |  |  |
| ֓֞֞֜֞֜֞֜֞֜֞֜֞֜֓֓֓֓֓֓֓֞֜֜֜֟֜֓֓֓֓֓֓֓֓֓֓֓֓      |   |                | Mr. John Fulmer 20a. Method of Disposition  | 20b. F   | Place of Disp   | position (Name of    |   | ppa Mary  | land, 210                            |  |  |
|  | t: Fit  |                | 1 Burial 2 Cremation 3 C 4 Donation 5 Other (Speci  | Removal from State   | cemetery, cr  | ematory or other pla | 1   | 01/05   | VAII.A . *                           |  |  |
| ֓֞֞֜֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֡֓֓֓֓֡֓֡֓֡֓֡֓ | artme<br>ortan<br>injur   |                | 21. Signature of Funeral Service Lice   | 1-4 V  | ans Ch  |                      |   | 24/05   | Forest Hi                            | ll, Maryland                             |  |
|  | Department of Healt<br>Important: If item 2<br>any injury or other<br>once.   |                | I from a fet  | han  | Ę   | Peaceful 1           | Alternați<br>Road Ti  | ves Fune  | ral&Crema                            | tion Ctr. P.A.                           |  |
| -  | _   |                | 21. Signature of Funeral Service Licensee  22. Name and Address of Facility Peaceful Alternatives Funeral & Cremation Ctr. P.A. 2325 York Road, Timonium Maryland 21093  23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  Approximate  |  |   |                      |   |   |                                      |  |  |
| D  | Physician<br>/Medical   |                | shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition  a. ANTERIO SCIENOTIC CANDIO VASCULAR DISEASE  interval Between Onset and Death  |   |                      |   |   |                                      |  |  |
|  |   |                | Immediate cause (Final disease or condition resulting in death)  a. ANTERIO SCIENTIC CAUDIO VASCULAR DISEASE > 109  |  |   |                      |   |   |                                      | c > wycars                               |  |
| E  | xaminer   |                | Conventially list and listen  | , CHRONIC  | REN   | INL FAIL             | LURE  |   |                                      | > 5 years                                |  |
|  | ate be executed by sician and the burial-transit  | ner            |   |  |   |                      |   |   |                                      |  |  |
| ,  |   | Examiner       | that initiated events C.  |  |   |                      |   |   |                                      |  |  |
| 20,  |   |                | resulting in death) Last Due to (or as a consequence of):   |  |   |                      |   |   |                                      |  |  |
| · (  | ng physinas the b   | dlcal          | •   | d  |   |                      |   |   |                                      |  |  |
| o XO   | ding  | Physiclan/Med  | IF FEMALE:  | 23c. If yes, outcome of pregna   | ancy  |                      |   |   | 23d Date of                          | delivery                                 |  |
| ם<br>פ                                       | been signed by the attending ph<br>should be detached for use as th   | clar           | in the past 12 months?  1 Live birth 2 Fetal death 3 Ectopic pregnancy  |  |   |                      | ;y  |   |                                      | 23d. Date of delivery  Month Day Year    |  |
| j }  |   | nysi           | 1 ☐ Yes 2 No 9 ☐ Unknown 5 ☐ Other (specify)  |  |   |                      |   |   |                                      |  |  |
| T 2  | ned t   | by P           | Part II. Other significant conditions   |  | sulting in the  | underlying cause gr  | ven in Part I.  | 23e. Did to   | obacco use contribute                | to the cause of death?                   |  |
| ecords,                                      | To the Hospital or Attending Physician: The law requires that the death certifical within 24 hours after death.  Within 24 hours after death.  To the Funantal Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the | ed b           | HYPERTENSION  |  |   |                      |   | 1 🗆 Y   | 1 ☐ Yes 2 ☐ 3 ☐ Probably 4 ☐ Unknown |  |  |
| ပ္<br>ပ                                      |   | ompleted       |   |  |   |                      | 4a. Was an autopsy findings availab prior to completion of cause of |   |                                      |  |  |
| ב<br>ב                                       |   | ШО             |   |  |   |                      |   | perfor  | rroed? death                         |  |  |
|  |   | Be C           | 25. Was case referred to medical examiner?  |  |   |                      | 26. Place of Dea  | ath (Check only o   |                                      |  |  |
| _  |   | To             | 1 Yes 2 No  | Hospital: 1 ☐ Inpatient 2 ☐  | 1 Inpatient 2 En/Outpatient 3 DOA 4 Nursing Hot   |                      |   | forme 5 Sesio   |                                      |  |  |
|  |   | on:            | 27. Manner of Death  1 ★ Natural 5 ☐ Pending  | 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? |   |                      | 28d. Describe how injury occurred                                   |   |                                      |  |  |
| ols :  | leath.  | catl           | Accident investigation  | 9  | M 1 Tyes 2 No  28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) |                      |   | 28f. Location (Street and Number or Rural Route Number,<br>City or Town, State) |                                      |  |  |
| UNISION                                      | in by   | Certification: | 4 Homicide determined   | 289. Place of injury - At n  |   |                      |   |   |                                      |  |  |
|  | urs a   |                | 29a. Certifier 12 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |   |                      |   |   |                                      |  |  |
| -  | 24 h<br>24 h<br>e Fun<br>etely  | edical         | (Check only 2 Medical Exe   | miner: On the basis of examina<br>and manner stated.                           | ation and/or  | nvestigation, in my  | opinion, death occu   | irred at the time,  | date and place, and o                | lue to the cause(s)                      |  |
| 4  | within<br>To the  | Me             | 29b. Signature and titr? of certifier 29c. License number 29d. Date signed (Month, D  |  |   |                      |   |   |                                      |  |  |
| ľ  |   |                | Martin A Knol MD D500 40 12-23-0  |  |   |                      |   |   |                                      | -05                                      |  |
|  | J.  |                | 30. Name and address of person who  | completed cause of death (Iter   |   |                      | 01-11   |   | 0 0 / - /                            | / 0                                      |  |
|  | N   |                | 1308 BUSINESS   | CENTEOL W  |   | 102 E                | DGENOC  | D, MI   | 0 604                                | 0  |  |
|  | Sta<br>Registr  |                | 31. Date filed (Month, Day, Year)   | 32. degistrar's Signa  | IK A  | barte                |   | •   |                                      |  |  |

State of Maryland / Department of Health and Mental Hygiene 15 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 12 FORD **JEAN** Physician 2005 11:30 44 /Medical 4c. County of Death Prince G 4a. Facility Name (If not institution, give street and number)
Prince Georges Hospital 4b. City, Town, or Location of Death Cheverly Examiner Georges | H Under 1 Year | H Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 932 6. Sex 5. Social Security Number 7. Age (In yrs. last birthday) 73 Yrs. 9. Birthplace (State or Foreign , Funeral Months Wash, DC 579-48-5616 1 □ M 2**X** F Director Usual Residence of Decedent 10c. City, Town or Location Seat Pleasant 10b. County 10d. Inside City Limits 28a-f show r then "neture!", or iteme 23e or 28e-f shov the Modical Examiner must be notified at MD Prince Georges 11 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20743 6508 Seat Pleasant Drive USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. within 72 hours after 1 ☐ Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2 ▼No Specify: Specify: Black ģ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15 Decedent's Education (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) 12th College (1-4or 5+) Verizon Manager 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 2 should be f and Mental H ie marked of Miles Theodore Roosevelt Miles Agnes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Peges 1 and 2 sh Department of Health and Important: If Item 27 ie m any injury or other traum once. 6508 Seat Pleasant Dr., Seat Pleasant, MD 20743 Joseph Ford Husband Baltimore. 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition cemetery, crematory or other place)
Chelternam Veterans Cemetery 12/23/2005 Chelterham, MD 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Bianchi 814 Upshur St. NW Wash, DC 20011 23a. Part 1. Enjer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CARDIO GENIC SHOCK **Physician** 4 HOURS disease or condition resulting in death) /Medical Due to (or as a consequence of):
ACUTE MYOCARDIAL Examiner INFARCTION 48 HOURS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine DIABETES MELLITUS burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Sicien certificate be Physician/Medical nding physical use as the t IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2X No Year 4 Pregnant at time of death 5 Other (specify) o 9 Unknown s been signed by t should be detact Д. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. SEPTIC SHOCK 23e. Did tobacco use contribute to the cause of death? Records. Completed by 1 Yes 2 No 3 Probably 4 Unknown FAILURE RENAL 24a. Was an autopsy performed?
1 ☐ Yes 2 € No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No FAILURE RESPIRATORY certificate of Vital : After this certifical funeral director, r Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 No Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Injury Division 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. To the Hospitel or Attendi within 24 hours efter death. To the Funeral Director: A investigation 2 Accident filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier w, Name and address of person who completed cause of death (Item 23a) (Type, Print)
David A. Gooray, MD 1450 Merchantile LAne #217 Largo, MD 20774 31. Date filed (Month, Day, Year) 32 negistrar's Signature State DEC 2 7 2005 Registrar

Elynn S Fine Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

23a, 27, 28a, b, c, d, e, f per MEO G-851 1/21/06 reb

State of Maryland / Department of Health and Mental Hygiene 05-08664 Unpend CT 1 - State Registrar Reg. No. U Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** FINE December 22 4:25 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. Cilv. Town, or Location of Death 4c. County of Death Examiner 6 Regalia Court Owings Mills Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month Day, 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1□ M 2 F 0970871956 Yrs 281-62-4215 49 Director Usual Residence of Decedent the Maryland 10a State 10c. City, Town or Location 10h County 10d. Inside City Limits irel', or iteme 23a or 28a-f show Director 1 ☐ Yes 2 No MD BALTIMORE OWINGS MILLS 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with 1 Department of Health and Mental Hygiene. Important: If Item 27 is marked other then "naturel", or Iteme 23a or 2 any injury or other treumatic avent, the Medical Examinar must be number. 6 REGALIA COURT 21117 U.S.A. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No WHITE Specify: 3 ☐ Widowed 4 🎇 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) RESIDENCY OFFICER BALTIMORE COUNTY SCHOOLS 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be **JACK** BEERMAN BARBARA ပ SAMBERG 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) AMY SOLOMON / DAUGHTER 27 SHADY NOOK AVENUE - CATONSVILLE, MD 21228 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) BETH EL MEMORIAL PARK 12/26/2005 RANDALLSTOWN, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respirator shock, or heart failure. List only one cause on each line. PIKESVILLE, MD 21208 Combines Drug [Diphenhydramine and Promethazine] intoxication

Due to (or as a consequence of): Immediate Cause (Final disease or condition resulting in death) Physician /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) attending physician and for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, by Physician/Medical IF FEMALE: If yes, outcome of pregnancy

1 Live birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown 3 Ectopic pregnancy Day Year 5 Other (specify) sate has been signed by the a page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown Be Completed 1 Yes 2 No 24b. Were autopsy lindings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 217 1 Yes funeral director. 25. Was case referred to medical examiner? 26. Place of Death Check only one Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Nursing Home 5 Residence 6200 ther (Specify) XXYes 2 No Certification; To Scene 28a. Date of Injury PnO 28b. Time of Pn 28c. Injury at (Month, Day Year) Injury 27. Manner of Death 28d. Describe how injury occurred 1 Natural 5 Pending To the Hospitel or Attending within 24 hours after death.

To the Funeral Director: Aft completely filled in by the fun 12/22/05 4:20 P.M 1 ☐ Yes 27 No investigation 2 Accident Unknown 6 X Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, lactory, office building, etc. (Specify) 28l. Location (Street and Number or Rural Route Number, City or Town, State) 6 Regalia Court House Owings Mills Md. 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 \*\*Medical Examiner:\*\* On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) OCME December 23, 2005 U 30. Name and address ol person who completed cause of death (Item 23a) (Type, Print) Pamela E. Southall, mi 111 Penn Street Baltimore, Maryland 21201 31. Date filed (Month, Day, Year) 32. Degistrar's Signature State Registrar

|                            |   |  | Please 1   | Type or Print in E  | Black Ind           | lelible Ink   | . Ensure All   | Copies A                                       | re Legible.                 |   |
|----------------------------|---|--|--|---|---------------------|---|--|--|-----------------------------|---|
|                            |   | State of Maryland / Department of Health and Mental Hygiene  1- For State Registrar  Certificate of Death  Registrar |  |   |                     |   |  |  |                             |   |
| N. S.                      | Physici<br>/Medi  | al   | 1. Decedent's Name (First, Middle, Last,  PEARLE N  4a. Facility Name (If not institution, give  | E   | G                   | REEL  | or Location of Death                                   | 2. Date of Death<br>Month                      | Day Year 2 4 2005           |   |
|                            | Examir<br>Funeral<br>Director   | ier  | 5. Social Security Number 6. Se. 214-40-7417   | RIS HOSPIC  |                     | If Under 1 Year<br>Months Days                                | TOWS If Under 24 Hrs. Hours Min.                       | 8. Date of Birth<br>(Month, Day, Y<br>APRIL 20 | BA.                         | LTIMOR E place (State or Foreign intry) RYLAND  |
|                            | ages 1 and 2 should be filed within 72 hours after death with the Maryland and Health and Mental Hygiene.  It: if item 27 is marked other than "natural", or items 23a or 28a-f show y or other traumatic event, If a Madical Examinar must be notified at  | Director   | Usual Residence of Decedent  10a. State 10b. County  MARYLAND N  10e. Street and Number  | /A 10c. Cit   | y, Town or Loc      | ation BA  | -LTIMO   |  | . Citizen of What Cou       | 10d. Inside City Limits 1,⊠Yes 2 □ No           |
| 10                         |   | Be Completed by Funeral  | 7/6 L/NN  11. Marital Status  1X Never Married 2□ Married  | UNARA STR  12. Was Decedent Ever in U.S Amed Forces? 1 □ Yes 2 ▼No                          |                     |   | 2/22<br>Hispanic Origin? (Spe<br>an, Mexican, Puerto F | 29 'U.   |                             | SA.  American Indian, White, etc.               |
| Maryland 21215-0036        |   |  | 3 Widowed 4 Divorced  15. Decedent's Edu (Specify only highest grad  | If Yes, Give<br>Year or Dates:<br>cation<br>e completed)                                    | 16a. Decede         | Tes 2 No  ent's Usual Occup ind of work done O NOT use retire | pation<br>during most of working                       | ng 16  | Specify: B                  | LACK  Industry (CINKNOW)                        |
| and 212                    |   |  | Elementary/Secondary (0-12) 9 HTGRADE 17. Father's Name (First, Middle, Last)  | College (1-4or 5+)  NURSES AIDE  18. Mother's Name (First, Middle, Maiden Surname)          |                     |   |  |  |                             |   |
| Baltimore, Maryla          |   | To   | 19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  7  7  8  8  8  9  9  9  9  9  9  9  9  9  9   |   |                     |   |  |  |                             |   |
| ***                        | Demit. Pages Department of important; if is any injury or any injury or one.  |  | 21. Signature of Funeral Service Licensee  22. Name and Address of Facility  23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  Approximate Interval Between Onset and Death  Approximate Interval Between Onset and Death  Due to (or as a consequence of): |   |                     |   |  |  |                             | AL HOME  10 21217  Approximate Interval Between |
| 68760,                     | To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit or | cai Examiner   | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last   | Due to (or as a conseq  Due to (or as a conseq  |                     |   |  |  |                             |   |
| .O. Box 68                 |   | by Physician/Medical   | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes   2   No   9   Unknown  | 3c. If yes, outcome of pregna 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of d 9 □ Unknown | I death 3 □E        | Ectopic pregnanc<br>Other (specify)                           | у  |  | 23d. Date of deliv<br>Month | ery<br>Day Year                                 |
| <b>Q</b>                   |   | Completed by Ph  |  |   |                     |   |  |  | bably 4 X Unknown           |   |
| Vital Re                   |   | To Be Comp   | 25. Was case referred to medical examiner?  1 □ Yes 2 ▼ No   | łospital: 1 □ Inpatient 2 □   | ER/Outpatient       | 3 DOA Ott   | 26. Place of Death                                     | 37 - 77  | d? death?                   |   |
| Division of Vital Records, |   | Certification; T   | 27. Manner of Death  1  Natural 5 Pending investigation  2  Accident investigation  3  Suicide 6 Could not be determined   | 28a. Date of Injury<br>(Month, Day Year)  | 28b. Time of Injury | 28c. Inju.<br>Wo  | ry at 2 No   | 8d. Describe how                               | injury occurred             |   |
| οį                         |   | Medical Cert   |  |   |                     |   |  |  |                             | stated.<br>o the cause(s)                       |
|                            | To the within To the comple   | Me   | 29b. Signature and title of certifier  |   |                     | 29c. Licens   | se number  |  | . Date signed (Month,       |   |

State Registrar

DR. TARIQ MAHMOOD

31. Date filed (Month, Day, Year)

DEC 2 7 2005 DHMH 17 Rev 1/2001

2300 DULANEY VALLEY RD. TIMONIUM, MD 21093

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Patricia Goldston 05-08649 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend item#8, Unpend item#23a, 27, pen E. (351, 1/25/16 TT State of Maryland / Department of Health and Mental Hygiene CT1 - For State Registrar · Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month TUA December 21 2005 9:35 PM /Medical facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Good Samaritan Hospital Baltimore 5. Social Security Number 6. Sex last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 10/27/57 9. Birthplace (State or Foreign Months Days Hours Min. (Month, Day, Year). Country) **Funeral** Months 1□ M 2 F 19-62-385 Director Usual Residence of Decedent the Maryland 10a. State 10b. County City, Town or Location 10d. Inside City Limits or 28a-f show the Medical Examiner must be notified at Director 1 Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? iteme 23a 06 Funeral filed within 72 hours after death Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. 1 Never Married 2 Married 2 **2**No Baltimore, Maryland 21215-0036 5 1 ☐ Yes 2 🗷 No Yes, Give Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced "natural", 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation
(Give kind of work done during most of working

jite DO NOT use retired) 16b. Kind of Business/Industry other then Elementary/Secondary (0-12) 17. Father's Name (First, Middle, Last) permit. Pages 1 end 2 should be filt Department of Health and Mental Hy Important: if Item 27 is marked oth any linury or other treumstic event 2008. Be 18. Mother's Name (First, Middle. 19b. Mailing Address (Street and Number or Rural Route Number 20a. Method of Disposition 20h 20c. Location - City or Burial 2 Cremation 3 Removal from State 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility sc. Circenstruverte 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Hypertensive Atherosclerotic Cardiovascular Disease /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 ettending physicien for use as the buria by Physician/Medicai as the IF FEMALE: . If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death Month Year Day 5 Other (specify) detached 9□ Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed 1 🗌 Yes 2 🗆 No 3 Probably 4 Unknown 24a. Was an autopsy performed? Yes Director: After this certific d in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To XXYes 2 □ No 1 Inpatient 2XXER/Outpatient 3□ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending Injury death investigation М 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours after To the Funeral Dire filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai To the I 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Dey, Year) OCME December 22, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

31. Date filed (Month, Day, Year) 32. Registrar's Signature 2005

McKing

111 Penn Street Baltimore, Maryland 21201

05-8343 Amend/Unpend Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Fig. C850, 12/29/05 TI State of Maryland / Department of Health and Mental Hygiene B.K.S MARIE GUZMAN 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Month **Physician** MARIA GUZMAN 10,  $_{
m DEC}$ 2005 /Medical Facility Name (If not institution, give street and number)
WASHINGTON ADVENTIST HOSPITAL 4b. City, Town, or Location of Death 4c. County of Death Examiner TAKOMA PARK MONTGOMERY If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month Day, Year) 6/9/1961 9. Birthplace (State or Foreign Country)
E1 Salvador 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1□ M 2 = F Months Days Hours Min 578-19-1829 44 Yrs. Director Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits other then "neturel", or Items 23a or 28e-f ehow rent, the Medical Examiner must be notified at 1 ☐ Yes 2 No Maryland Montgomery Takoma Park 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code ā 8201 Flower Ave. 20912 Apt 4 Salvador Funera 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after Hygiene. 1 Never Married 2 Married Specify: El Salvador Baltimore, Maryland 21215-0036 Yes 2□ No Specify: Hispanic δ 3₺ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Supervisor Laundry 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) . Pages 1 and 2 should be fill ment of Health and Mental H tant: If Item 27 le marked off lury or other treumatic even Be Monico Guzman Prudencia Franco ဂ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jose Guzman - Brother 2436 Sciaaca Rd; Spring TX 77373 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 K Removal from State permit. Page Department Important: If eny injury o San Francisco de Asis 12/29/2005 San Miguel, El Salvador 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hines-Rinaldi Funeral Home Hines-Rina.

11800 New Hampshire Ave; Si

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 11800 New Hampshire Ave; Silver Spring MD 20904 Approximate Interval Between Immediate Cause (Final disease or condition **Physician** Pulmonary emboli /Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine been signed by the attending physicien and should be detached for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetel death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

Yes 2 No 24a. Was an page 5 has autopsy performed? certificate or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 3 DOA 28c. Injury at Work? Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred 20 ER/Outpatient 2 1XYes 2 No After thi 28a. Date of Injury (Month, Day Year) 27. Manner of Death Certification; 1 Natural 5 Pending within 24 hours after community to the Funeral Director; After community of the funeral part of the funera 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide unk 28f. Location (Street and Number or Rural Route Numbellink City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai 29a. Certifier (Check only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E DEC. 11, 2005

Registrar

DHMH 17 Rev 1/2001

State

RON

7 2005

31. Date filed (Month, Day, Year)

war wy

32. Registrar's Signature

who completed cause of death (Item 23a) (Type Print) STREET, BALTIMORE, MARYLAND 21201

|                 |  |                       | 1 - Stamend Item#5 I  |  | ryland / Dep<br>4/12/06 (  | artment of                       | f Health a<br>of Death             |                              |                                      |  | 5 41683  |
|-----------------|--|-----------------------|---|--|--|----------------------------------|------------------------------------|------------------------------|--------------------------------------|--|--|
| В               | Physici  | an                    | Decedent's Name (First, Middle, La  | st)  |  |                                  |                                    |                              | <ol><li>Date of Deal Month</li></ol> | Day                                    | 3. Time of Death   |
| 000             | /Medic   | al                    |   | LAND   |  | 41. Cit. T-                      | 1 1:                               | -4 Dooth                     | DECEME                               |  | 2005 7:00 A M  |
| 1               | Examir   | er                    | 4a. Facility Name (If not institution, gir  | e street and number)   |  | LANHAI                           | n, or Location of                  | or Death                     |                                      | 4c. County o                           | CE GEORGES   |
| -               | Funeral  |                       | REXFORD PLACE  5. Social Security Number 6. 9  219–32–4240  | Sex 7. Age   | (In yrs. last birthday   | If Under 1 Ye                    | ar If Under                        |                              | B. Date of Birt                      |  | Birthplace (State or Foreign Country)  |
|                 | Director   |                       | 219-32-4240<br>2 <del>19-30-4240</del>  | 1□M 2 <b>X</b> 1F 75   | Yrs.   | Months Da                        | ys Hours                           | Min.                         | (Month, Da<br>1-22-                  | -1930                                  | VA   |
|                 | pu k   |                       | Usual Residence of Decedent  10a. State 10b. County   |  | 10c. City, Town or L   | ocation                          |                                    |                              |                                      |  | 10d. Inside City Limits  |
|                 | darylist sho   | 5                     | MD BALTIM   |  |  | STATIO                           | N                                  |                              |                                      |  | 1 X Yes 2 □ No   |
|                 | r 28a-   | Director              | 10e. Street and Number  |  |  | 10f. Zip Cod                     | 8                                  | · <u>-</u>                   |                                      | 10g. Citizen of W                      | hal Country?   |
|                 | h with   |                       | 154 CARVER ROAD   |  |  | 21                               | 222                                |                              |                                      | USA                                    |  |
|                 | ams ams  | Funerai               | 11. Marital Status  | 12. Was Decedent Ev<br>Armed Forces?                                     | ver in U.S. 13.  | Was Decedent                     | of Hispanic Ori<br>Suban, Mexicar  | gin? (Spec                   | ify Yes or No<br>ican, etc.)         |  | - American Indian,<br>White, etc.  |
| 36              | hours after death with the Maryland<br>tural; or Itams 23a or 28a-f show<br>al Examinal must be notified at  | by Fu                 | 1 Never Married 2 Married 3 X Widowed 4 Divorced  | 1 ☐ Yes 2 📉 No   |  | 1 ☐ Yes 2 💢                      |                                    |                              |                                      | Specify:                               |  |
| 00              | d within 72 hours giene.<br>ar than "natural",<br>"Ina Medical Exa   |                       | 15. Decedeni's E  | Year or Dates:   | 16a Dece   | dent's Usual Oc                  | cupation                           |                              |                                      | 16b. Kind of Bus                       | BLACK<br>siness/Industry   |
| 215             | within 72<br>ene.<br>than "nat   | piet                  | (Specify only highest gr<br>Elementary/Secondary (0-12)   | ade completed)  Cotlege (1-4or 5+  | (Give  | kind of work do<br>DO NOT use re | ne during mos                      | t of working                 | g                                    |  |  |
| 21215-0036      | filed witl<br>Hygiene<br>other the   | Completed             | 8   | 00110g0 (1 101 01  | CUS  | STODIAN                          |                                    |                              |                                      | BALTIMO                                | RE CO. P.S.  |
| Maryland        | d ta b y   | Be                    | 17. Father's Name (First, Middle, Las.  | ")   |  |                                  | 18. Mothe                          | er's Name                    | (First, Middle,                      | Maiden Sumame                          | )  |
| <del>y</del> la | 2 9 2 0  | မ                     | WALTER HUGHES   | Circo Cointh   | 40h M-11   |                                  |                                    |                              | RAWLEY                               | . C T                                  | 7-0-11   |
| Mai             | s 1 and 2 should Health and Mitem 27 is mari   |                       | 19a. Informant's Name/Relationship HENRY GARLAND/NE   | •  |  | CHESTE                           |                                    |                              |                                      | er, City or Town, S<br>IMORE。MI        |  |
|                 | tom 2  |                       | 20a. Method of Disposition  |  | 20b. Place of Disp   | osition (Name of                 |                                    | Da                           |                                      |  | City or Town, State  |
| OE              | 0 0  |                       | 1 XBurial 2 ☐ Cremation 3 € 4 ☐ Donation 5 ☐ Other (Speci   |  |  | matory or other;                 | 1                                  | 12-2                         | 9-2005                               | ALTON,                                 | VA   |
| Baltimore,      | permit. Page<br>Depertment of<br>Important: If<br>any injury or<br>once.   |                       | 21. Signature of Funeral Service Lice   |  | the second secon |                                  |                                    |                              |                                      |  | SONS F.H., INC   |
| m m             | 80E = 8  |                       | James 9   | morto  |  | 1701-31                          |                                    |                              |                                      | IMORE, M                               |  |
|                 | Physician<br>/Medical<br>Examiner  | Examiner              | shock, or heert failure. List only Immediate Cause (Final disease or condition resulting in dealh)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events | a. Chron   | consequence of):   | troctive                         | 2 Pul                              | monci                        | ry D                                 | Pisease                                | Inierval Belween<br>Onset and Death  |
| .O. Box 68760,  | The law requires that the death certificate be executed tie has been signed by the attending physicien and bage 2 should be detached for use as the burial-transit | Physician/Medical Exa | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown   |  | Fetal death 3  | □Ectopic pregna□ Other (specify  |                                    |                              |                                      | 23d. Date<br>Mont                      | of delivery<br>th Day Year   |
| ₾.              | res that<br>igned b  | by Pt                 | Part II. Other significant conditions   | contributing to death but  | not resulting in the   | underlying cause                 | given in Part I                    |                              | 23e. Did to                          | obacco use contri                      | bute to the cause of death?  |
| rds             | w require<br>been sig<br>should b  | ed t                  | Hypertension,   | Hyperlip   | idemia,  | Peni                             | phero                              | 2-1-                         | 1                                    | res 2□No 3                             | 3 Probably 4 Unknown   |
| Vital Records,  | The law re<br>ate has be<br>page 2 sho   | Completed             | 2   | ase, Chr   |  | enal F                           | ailore                             |                              | 24a. Was<br>autop<br>perfo           | rmed? pr                               | ere autopsy findings available for to completion of cause of eath?  Yes 2 \sum No  |
| ital            |  | Bec                   | PSOCIASIS De 25. Was case referred to medical examiner?   | pression ·   | WITH 13  | ychosi:                          |                                    | of Death                     | (Check only o                        | 1                                      |  |
| of V            | Physicien:<br>this certific<br>ral director.   | 70                    | 1 Yes 2 No  |  | t 2□ER/Outpatie  | nt 3 DOA                         | Other: 4 Nu                        | ırsing Hom                   | e 5 ☐ Resid                          | dence 6 Other                          | (Specify) Living   |
| n o             | ding P<br>h.<br>After t<br>funera  | ion:                  | 27. Manner of Death 1 X Natural 5 ☐ Pending   | 28a. Date of Injury<br>(Month, Day                                       | Year) 28b. Time (  |                                  | njury at<br>Work?                  |                              | 3d. Describe f                       | now injury occurre                     | d ,  |
| Division        | eat<br>or:   | Certification:        | 2 Accident investigation 3 Suicide 6 Could not to   | De Diago of Injure   | y - At home, farm, si  |                                  | 1 Yes 2                            |                              | Rf Location (5                       | Street and Number                      | r or Rural Route Number,   |
| Ď               | F 6 F C  | erti                  | 4 Homicide determined   | building, etc.   | (Specify)  | root, ladiory, on                |                                    |                              | City or Tov                          |  | or its all its all its all of its |
|                 | To the Hospitel c<br>within 24 hours of<br>To the Funerel D<br>completely filled in  | edicai C              | 29a. Certifier 1 Certifying P (Check only 2 Madical Exa   | hysician: To the best of<br>minar: On the basis of e<br>and manner state | examination and/or in  | th occurred at the               | e time, date an<br>ny opinion, dea | nd place, ar<br>ulh occurred | nd due to the                        | cause(s) and man<br>date and place, ar | ner as stated.<br>nd due to the cause(s)   |
|                 | To the within 2 To the complet   | Me                    | 29b. Signal are and title of certifier  |  |  | 29c. Lic                         | ense number                        |                              |                                      | 29d. Date signed                       | (Month, Day, Year)   |
| 0               | $\prec$  |                       | > Xul   | M.D.   |  | DS                               | 5559                               |                              | 5                                    | Decemb                                 | er 22, 2005  |
| 6               | \  |                       | 30. Name and address of person who  |  |  | , Print)                         |                                    |                              | ~                                    | -                                      | 20770  |
| 2               |  |                       | Thomas Mas<br>31. Date filed (Month, Day, Year)   | Slin, MD   | 7525   | Green                            | nway (                             | Cent                         | er Dr                                | Gree                                   | 20770<br>20770<br>enbelt, MD   |
|                 | Sta<br>Registi   |                       | DEC 2 7 200   | Registrar  | A Signature  | we                               |                                    |                              |                                      |  |  |

05-08712 ESTER GUFFY WHM

Unpend item#23a,PII,27,28a-f,pen/E,0852,27/06 II

State of Maryland / Department of Health and Mental Hygiene [] 5 1 - For State Registrar Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** Guffy DECEMBER 24, Esther Naomi 2005 11:15 A<sup>M</sup> /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** GILCHRIST HOSPICE TOWSON BALTIMORE CO | House | If Under 24 Hrs. | B. Date of Birth (Month, Day, Year) | July 15, 19 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🏋 F 210-16-4653 81 Yrs. 1924 Pennsylvania Director Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or Itama 23a or 28e-1 show the Medical Examiner must be notified at MD 1 ☐ Yes 2X No Howard Ellicott City Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3478 Blackberry Lane 21042 USA filed within 72 hours after deeth 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Be Completed by 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) U.S. Navy Accountant permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: It Item 27 is marked oth any Injury or other traumatic svent SDE. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Breon Unk. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ellicott City, MD Wellard R. Guffy, husband 3478 Blackberry Lane 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ▼Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc. 12/26/05 Baltimore, MD 21. Signature of Funeral Service Licensee George MacNabb Cremation Society of Maryland, Ser E. Mr. M. Baltimore, 299 Frederick Road MD23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Carvedilol toxicity complicating atherosclerotic Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician disease, mitral valve prolapse and lymphoma /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner attending physicien and for use as the burial-transit Due to (or as a consequence of) Records, P.O. Box 68760, Completed by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) ned by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Dementia 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Nes 2 No Yes Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) examiner: Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) င္ 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification; 1 Natural 2 Accident 5 Pending investigation 12/23/05 1 ☐ Yes XX No unk

To the Hospital or Attending Physician: The law requires thet the death certificate be executed within 24 hours after death. To the Funerel Director: After this certificate hes been signed by the attending physicien and Division of Vital s after dec. filled in by

-punā

Jacober

6 Could not be determined

3 ☐ Suicide

29a Certifier

Medical

4 Homicide

29b. Signature and title of certifier

and manner stated

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

29c. License number OCME

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Dey, Year) DECEMBER 25, 2005

incorrectly dispensed medication

28f. Location (Street and Number or Rural Route Number, City or Town, State) 34.78 Blackberry Lane Ellicott City, 10

NO completed cause of death (Item 23a) (Type, Print)

home

31. Date filed (Month-Day, Xe

111 PENN STREET, BALTIMORE, MARYLAND, 21201

State Registrar

State of Maryland / Department of Health and Mental Hygiene 1 5 1 - For Stete Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Day Year

December 22, 2005 **Physician** Richard Allen Giantonio 8:30 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 1205 St. Agnes Lane, Apt. C **Baltimore** Gwynn Oak | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year SEP 23, 19 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1**X**M 2□ F Yrs. 020-34-0779 60 1945 Massachusetts Director Usual Residence of Decedent 10a. State 10b. Count 10c. City. Town or Location 10d. Inside City Limits 23a or 28a-f ehow other treumatic event, the Madical Examinar must be notified at 1 ☐ Yes 2X No Directo Gwynn Oak Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1205 St. Agnes Lane, Apt. C 21207 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) "naturel", or iteme 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 le marked other than "naturel", or ite 1 ☐ Yes 2 📉 No If Yes, Give Year or Dates: 1X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White Specify: δ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Baltimore County College (1-4or 5+) Elementary/Secondary (0-12) Drug & Alcohol Counselor Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Caroline Mangano Paul Peter Giantonio 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ronald J. Giantonio/Brother 19 Thomas Road Methuen, MA 01844 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc. 12/23/05 Baltimore, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Cremation Society of MD, Inc. George MacNabb ny a MH 299 Frederick Road Baltimore, MD 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Endstage Hepatic Cirrhosis 1 month /Medical Due to (or as a consequence of) Examiner 5 years Active Hepatitis B & C sequentially flet our ditioner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine as the burlal-transit certificate be executed Chronic Anemia 1 month and Due to (or as a consequence of) the attending physician P.O. Box 68760 Physician/Medical use s IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 1 Live birth 2 | Fetal death in the past 12 months? õ Month Dav Year 4☐Pregnant at time of death 5 ☐ Other (specify) page 2 should be detached 9□ Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed Deen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 1 Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director; After this certifica Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) ပ 1XYes 2□No 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Injury 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 🔣 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature ar title of certifier 29d. Date signed (Month, Day, Year) D29769 December 23, 2005 30. Name and I ddress of person who completed cause of deat (Item 23 (Type, Print) M.D. 516 N. Rolling Road Baltimore, MD 21228 Marcelino D. Albuerne 31. Date filed (Month, Day, Year) State DEC 2 7 Registrar 2005

DHMH 17 Rev 1/2001

|                  | 05-0846<br>CT  | 04                           | Please<br>Amend item#8,1   | 9 Type or Print in<br>9a-b, perFH, G85<br>State of Maryla<br>23a,PII,27, perFE, G | Black In         | delible in<br>7-05 TT                 | k. Ensure A                                 | II Copies A                                   | re Legib              | le.  |
|------------------|--|------------------------------|--|---|------------------|---------------------------------------|---|---|-----------------------|--|
|                  | 01   | •                            | 1 - For Unpend item#   | 23a,PII,27,penE,  | 851,1711<br>Ce   | rtificate o                           | f Death                                     | vieritai mygi<br>Re                           | g. No.                | 5 4 6 8 6  |
|                  |  |                              | 1. Decedent's Name (First, Middle, L   | ast)  |                  | ^ 1                                   |   | 2. Date of Death<br>Month                     |                       | 3. Time of Death                                   |
|                  | Physici<br>/Medio  |                              | Kichard  |   | (                | 2000                                  | man   | Decembe                                       |                       | 005 12:33 A <sup>M</sup>                           |
|                  | Examin   |                              | 4a. Fecility Name (If not institution, g                                     | ive street and number)  |                  | 4b. City, Town                        | , or Location of Death                      |   | 4c. County of         | f Death  |
|                  |  |                              | Johns Hopkins H  | Mospital (1980)   |                  | Baltim                                | ore   |   | N/A                   |  |
|                  | Funeral  |                              |  | Sex 7. Age (In yrs  |                  | If Under 1 Year<br>Months Day         |   | 8. Date of Birth<br>(Month, Day,              | Year)                 | 9. Birthplace (State or Foreign Country) Virginia  |
|                  | Director   |                              | 216-52-2869  | 55  | Yrs.             |                                       |   | May 2,1                                       | 950                   | Hary land  |
|                  | and and  |                              | Usuel Residence of Decedent  10a. State 10b. County                          | 10c. C  | ity, Town or Lo  | ocation                               |   |   |                       | 10d. Inside City Limits                            |
|                  | Mary   | ō                            | MD N   | A   | Bal              | timo                                  | re  |   |                       | 1XYes 2□No   |
|                  | 28a  | rec                          | 10e. Street and Number   |   | 0001             | 10f. Zip Code                         |   | 10  | g. Citizen of Wh      | nat Country?                                       |
|                  | death with the Maryland<br>ma 23a or 28a-f ahow<br>rmail be notifiad at  | Funeral Director             | 2413 Hoffm   | an St.  |                  | 2                                     | 1212  |   | US                    | 3A   |
|                  | death<br>ma 2  | ner                          | 11. Marital Status   | 12. Was Decedent Ever in U  | J.S. 13.         | Was Decedent of                       | f Hispanic Origin? (Spuban, Mexican, Puerto | pecify Yes or No-                             |                       | - American Indian,                                 |
| •                | after<br>or its  | ₫                            | 1 Never Married 2 Married  | Armed Forces?<br>1 Aryes 2 □ No<br>If Yes, Give                                   |                  | 1.7                                   |   | Hican, etc.)                                  |                       | , White, etc.                                      |
| 3                | hours after<br>tural', or its  | d b                          | 3 ☐ Widowed 4 ★ Divorced   | Year or Dates:  |                  | 1□Yes 247N                            | lo Specify:                                 |   | Specify:              | Black  |
|                  | 72 h<br>natu   | Completed by                 | 15. Decedent's (Specify only highest of                                      | Education<br>trade completed)   | (Give            | dent's Usual Occ                      | ne during most of wor                       | king 1  | 6b. Kind of Busi      | iness/Industry                                     |
| 1 1              | nen.   | Id II                        | Elementary/Secondary (0-12)  | College (1-4or 5+)  | lite.            | DO NOT use reti                       | 0 11  |   | JOOL IN               | ater and waste                                     |
|                  | e filed within<br>al Hygiene.<br>I other then '  | S                            | 17 February Name (First Middle Le  | 4   | Dar              | Hmor                                  |   |   |                       |  |
| man yidin        | be fi  | Be                           | 17 Father's Name (First, Middle, Las   | st)   | A 2 -1.          | 20010                                 | . ALICE                                     | ie (First, Middle, M.                         | aiden Sumame)<br>AA < | )  |
|                  | 2 should be and Mental I a marked or raumatic ave  | 유                            | r NCrut a  | Constant Co   | 30001            |                                       |   |   |                       |  |
|                  | s I and 2 should be filed within 72 hours after death with the Marylan f Health and Mental Hygiene. If Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23s or 28s-1 show then traumatic avent, the Medical Examinar must be notified at  |                              | 19a. Informant's Name/Relationship   | (Type, Print) 50 m  | 2,241            | B Hoff <b>ma</b>                      | et and Number or Ru<br>n Street I           | Baltimore                                     | MD 212                | 13 (2ip Code)                                      |
|                  | t and<br>Health<br>em 27<br>ther tr  |                              | 20a. Method of Disposition   |   | Place of Dispo   | sition (Name of                       |   | Date 2  | Oc. Location - C      | ity or Town, State                                 |
|                  | 00   |                              | 1 Burial 2 ☐ Cremation 3   | ☐Removal from State   | cemetery, crei   | matory or other p                     | nlace)                                      |   |                       | *  |
|                  | permit. Pag<br>Depertment<br>Important: if<br>any injury o   |                              | 4 Donation 5 Other (Spec   |   | RRISON           | FORRET (                              | EMETARY /2-                                 | 21-05 OU                                      | 100,4001              | ILLS MANJLAND                                      |
|                  | Depending of the population of |                              | 21. Signature of Fugeral Service Lic   | onsee   | 2                | z. Name and Add                       | dress of Famility                           | rvices P.                                     | A Ba                  | Hmore, Ma  |
|                  |  |                              | 23a. Part1. Enter the disease, or co   | maliantians that savened the des  |                  | 431 203                               |   | St.   |                       | 21213  |
|                  |  |                              | shock, or heart failure. List on   | y one cause on each line.   | ith. Do not em   | er the mode of d                      | lying, such as cardiac                      | or respiratory arres                          | st,                   | Approximate<br>Interval Between<br>Onset and Death |
|                  | Physician  |                              | Immediate Cause (Final disease or condition resulting in death)              | a. Atherosclerot  | tic Cardi        | ovascular                             | Disease                                     |   |                       |  |
|                  | /Medical<br>Examiner   |                              | 1  | Due to (or as a conse   | quence of):      |                                       |   |   |                       |  |
|                  |  | _                            | Sequentially list conditions, if any, leading to introducte                  | b. Eue to (or as a conse  | number of):      |                                       |   |   |                       |  |
|                  | led<br>Isit  | ulu                          | cause. Enter Underlying<br>Cause (Disease or injury<br>that initiated events | C 00 10 (3 do 3 nonio   | quarier org.     |                                       |   |   |                       |  |
|                  | be executed<br>icien and<br>burial-transit   | Examiner                     | that initiated events resulting in death) Last                               | c. Due to (or as a conse  | quence of):      |                                       |   |   |                       |  |
|                  |  | <u>a</u>                     |  |   |                  |                                       |   |   |                       |  |
|                  | death certificate<br>e ettending phys<br>d for use as the  | Completed by Physician/Medic |  | d   |                  |                                       |   |   |                       |  |
|                  | centi<br>nding<br>use a  | Ž                            | IF FEMALE:<br>23b. Was decedent pregnant                                     | 23c. If yes, outcome of pregr   |                  |                                       |   |   | 23d. Date             | of delivery  |
| 1                | ette<br>d for  | clar                         | in the past 12 months?   | 1 Live birth 2 ☐ Fet<br>4 ☐ Pregnant at time of                                   |                  | ☐Ectopic pregnar<br>☐ Other (specify) |   |   | Month                 |  |
|                  | that the deed by the detached  | nys                          | 9 Unknown  | 9□ Unknown  |                  |                                       |   |   |                       |  |
|                  | uires that<br>signed k<br>d be det   | γP                           | Part II. Other significant conditions  | contributing to death but not re  | sulting in the u | nderlying cause                       | given in Part I.                            | 23e. Did toba                                 | acco use contrib      | oute to the cause of death?                        |
| 3                | een sign   | D D                          | Chronic Obstructive  | Pulmonary Disease   |                  |                                       |   | 1 ☐ Yes                                       | 2 □ No 3              | Probably 4 Unknown                                 |
| 5000             | > 0 50   | lete                         |  |   |                  |                                       |   | 24a. Was an                                   | 24b. We               | ere autopsy findings available                     |
| 2                | The lavelete has   | mc                           |  |   |                  |                                       |   | autopsy                                       | ed? de                | or to completion of cause of<br>ath?               |
| 3                | ician: Th<br>certificete<br>rector, pag  | Ö                            | 25. Was case referred to medical   |   |                  |                                       | 26 Place of Dog                             |   |                       | Yes 2 No   |
| -                |  | To B                         | examiner?<br>1∭XXes 2 □ No   | Hospital: 1 ☐ Inpatient 20  | X ER/Outpatier   | nt 3 DOA                              | )there                                      | th <i>(Check only one)</i><br>ome 5 ☐ Residen |                       | (Second)   |
| 5                | g Physical dispersal di  |                              | 27. Manner of Death  | 28a. Date of Injury<br>(Month, Day Year)  | 28b. Time o      |                                       |   | 28d. Describe how                             |                       |  |
| DIVISION OF VICE | 着っ多草   | ig<br>ig                     | 1 ☐Natural 5 ☐ Pending<br>2 ☐ Accident investigati                           |   | Injury           |                                       | /ork?<br>☐Yes 2☐No                          |   |                       |  |
| 2                | Attending r death.  actor: After by the funer  | il C                         | 3 ☐ Suicide 6 ☐ Could not<br>4 ☐ Homicide determine                          | 286. Place of injury - At i   | nome, farm, sti  | reet, factory, offic                  | :e  | 28f. Location (Stre                           | et and Number         | or Rural Route Number,                             |
| 5                | effe<br>Direction of in the  | Certification:               | 4 [] Homicide  | building, etc. (Spec  | ify)             |                                       |   | City or Town,                                 | State)                |  |
|                  | ospital<br>hours e<br>uneral<br>ily filled   |                              | 29a. Certifier 1 Certifying  | Physician: To the best of my kn   | lowledge, deat   | h occurred at the                     | time, date and place.                       | and due to the cau                            | use(s) and mann       | ner as stated.                                     |
|                  | To the Hospital or Attand<br>within 24 hours efter death<br>To the Funeral Director:<br>completely filled in by the  | Medical                      | (Check only 2 Medical Ex-  | aminer: On the basis of examinand manner stated.                                  | ation and/or in  | vestigation, in m                     | y opinion, death occur                      | red at the time, dat                          | e and place, an       | d due to the cause(s)                              |
|                  | To th<br>withir<br>To th<br>comp   | ž                            | 29b. Signature and title of certifier  |   | )                | 29c. Lice                             | ense number                                 | 29  | d. Date signed (      | (Month, Day, Year)                                 |
|                  | -  |                              | Mot.   | 1 cm is - to  | 10h.             | OCM                                   | ₹.  | De  | cember                | 16, 2005   |
|                  |  |                              | 30. Name and address of person wh  | o completed cause of death (Ite   | m 23a) (Type,    |                                       |   | , DC  | JUILIOUE              | 10, 2007   |
| 0                | T  | - 1                          | MATRICIA A   | TONICA-Kall   | SKM              | P 111 Pe                              | enn Street                                  | Baltimo                                       | re, Mar               | yland 21201  |
|                  | Sta  | ite                          | 31. Date filed (Month, Day, Year)  | 32 Registrar's Sign   |                  | artes                                 |   |   |                       |  |
|                  | Registr  | ar                           | DEU 272  | UUU LEAGUAS /   | 15               |                                       |   |   |                       |  |

Richard Goodman

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 15 Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) Month Day Vear 8:16 PM Physician GREGA SABRINA 16 2005 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number, Examiner BALMAN-CITY NA MARYLAND Monicar (GUIM UNIVERSIN OF If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 05. 19. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (in yrs. last birthday) **Funeral** Months Days Hours 1 ☐ M 2 101 F Yrs 309.90.1671 W Director Usual Residence of Decedent 10d. Inside City Limits death with the Maryland 10c. City. Town or Location 10a State 10b. County 28a-f ehow the Mudical Examiner must be notified at 1 Tyes 2 No Completed by Funeral Director WICOMICO MD SALISBURY 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code or Items 23a or STREET 21286 USA 108 PRINCE 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: WHITE 3 □ Widowed 4 □ Divorced "natural", 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry LAK 15 Decedent's Education (Specify only highest grade completed) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) NIA 9 14 GRADE 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be . Pages 1 and 2 should be fil timent of Health and Mental H tant: If item 27 is marked oth jury or other traumatic sven JOHNNY M. GREGG ELAINE LEDMAN 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) MCHENRY P. D. BOX PETERS 84 1HOMAS MUCLE 20b. Place of Disposition (Name of cemetery, crematory or other place) Baltimore, Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State permit. Page Department of Important: If eny injury or once. 12 23 05 BALTIMORE GREENMOUNT 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility CREMATION SERVICE 21. Signature of Funeral Service License anon 5151 BALTO . NATU PIKE BALTO . MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 1mmediate Cause (Final YEAR Physician PSEUSOANEUM3M ACAME disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine and Il-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): physicien a s the burial-Records, P.O. Box 68760. Physician/Medical 35 attending IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year ō in the past 12 months? Month Day 4□Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No detached the 9☐Unknown 9 NUnknown ģ signed i Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 XUnknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Wasan 1 XYes 2 No Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director. D Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 1 W Yes 2 □ No 2 ER/Outpatient 3 DOA 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification: 1 Natural 2 Accident Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the lime, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of 29c. License number 29d. Date signed (Month, Pay, Year) 16 AV4176435 M12538 m 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GIEONE SMEET

DHMH 17 Rev 1/2001

State

Registrar

SINA

31. Date filed (Month Day, Year)

MOMNIE

2005

32. Fagistrar's Signature

, m

BAINMONE

NO

21201

Amend item#5 Please Type of Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene 15 1 - State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dec 24, Physician 2005 1:57 P M Melvin Atlas Hughes /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore-Washington Medical Center Glen Burnie Anne Arundel | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Jan 19, 5. Social Security N. 8437 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1₩ 2□F Baltimore MD 214-40-<del>8436</del> 62 Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show r then "natural", or items 23a or 28a-f show the Medical Examinar must be notified at 1 ☐ Yes 2 ☐ No Director MD Anne Arundel Severn 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 21144 USA 793 Martin Court West 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status filed within 72 hours after 1 Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2K No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Black. Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7; Department of Health and Mental Hygiene. Important: If Item 27 is marked other then "ns eny Injury or other traumatic event, the Mustic once. Elementary/Secondary (0-12) Cotlege (1-4or 5+) 12 Truck Driver Hauling 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Naomi Vanlandingham Melvin Leon Hughes 19 Approximately (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 793 Martin Court West, Severn, MD 21144 Melvina Hughes Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 12-27-05 Bayview Crematory Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) Gregory Fire 21. Signa -22. Name and Address of Facility Fink Funeral Home, P.A. 426 Crain Hwy SW, Glen Burnie, MD 21061 MO1148Part1. Enter the disease, or shock, a heart failure. List Approximate Interval Between Onset and Death plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. Immediate Cause (Final disease or condition resulting in death) OR PULMONALE Physician YEARS /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) anding physicien and use as the burial-transit be executed resulting in death) Last Due to (or as a consequence of): signed by the attending physicien I be detached for use as the buria Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Dav Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ CARDIOMYOPATHY ONGESTIVE 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed 2 No 1 ☐ Yes 1 ☐ Yes 2 ☐ No or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death | Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 No 1 Inpatient 2 X ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) After thi 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pendina 1 ☐ Yes 2 ☐ No death. investigation М 2 Accident the Director 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours after To the Funaral Dire the Hospital 29a. Certifier 1 ី Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature apolitile of certifier 29c. License number 031136 aulin 0 WALLACE MD GOOS KILBRIDE RD, BATIMOLE MD ZIZZL 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, State Registrar DHMH 17 Rev 1/2001

**ORIGINAL** 

|        |               |   |                | State of Maryland / Depa   | rtment of Health and Me<br>tificate of Death  | ental Hygier                             | -000                               | 1689   |
|--------|---------------|---|----------------|--|---|--|------------------------------------|--|
|        | 4             | 200   | 0              | Decedent's Name (First, Middle, Last)  |   | 2. Date of Death                         |                                    | 3. Time of Death                               |
|        |               | Physicia  |                | Melvin Joseph Hauer  | 1   | 1  | 24, 2005                           | 11:00 AM                                       |
|        |               | /Medic  | -              | 4a. Facility Name (If not institution, give street and number)   | 4b. City, Town, or Location of Death  | cember                                   | 4c. County of Death                | ITTOOT   |
| V      | - <b>3</b> .5 | Examin  | er             |  | Baldin  |  | Harford                            |  |
|        |               | Funeral   |                | 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)  | If Under 1 Year If Under 24 Hrs. 8  | B. Date of Birth<br>(Month, Day, Yea     |                                    | place (State or Foreign                        |
|        |               | Director  |                | 317-07-4767 12M 20F 89 Yrs.  | Months Days Hours Min.  |  |                                    | yland  |
|        | *             | ס   |                | Usual Residence of Decedent  |   | -0. 0, 11                                |                                    | 1  |
|        |               | nylan<br>how  |                | 10a. State 10b. County 10c. City, Town or Loc  | ation   |  | 1                                  | Od. Inside City Limits                         |
|        |               | a-f-  | cto            | MD Battimore Bose  | dale  |  |                                    | 1 Yes 2 No                                     |
|        |               | or 28   | Director       | 10e. Street and Number   | 10f. Zip Code   | 10g. (                                   | Citizen of What Cour               | ntry?  |
| Q      |               | 23a   |                | 5454 King Arthur Circle  | 21237   | (  | 1SA                                |  |
| 0      |               | items<br>items  | Funerai        | 11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  13. W   | vas Decedent of Hispanic Origin? (Spec<br>Yes, specify Cuban, Mexican, Puerto Ri          | fy Yes or No-<br>can, etc.)              | 14. Race - Americ<br>Black, White, |  |
| _      | 9             | or it   | Y.             | 1 Never Married 2 Married 1 Pres 2 No  | ☐ Yes 2 No Specify:   |  | Specify:                           | * 1  |
|        | 21215-0036    | within 72 hours after death with the Maryland<br>ene.<br>Than "natural", or items 23s or 28s-f show<br>the Madical Examiner must be notified at | d by           | 3 ☐ Widowed 4 Na Divorced Year or Dates:   |   |  | W                                  | rite   |
|        | <u>ιγ</u>     | "nat  | Completed      | 15. Decedent's Education 16a. Decedent (Specify only highest grade completed) (Give k  | ent's Usual Occupation<br>kind of work done during most of working<br>OO NOT use retired) | 7  | Kind of Business/Inc               | dustry   |
|        | 42            | withir<br>ene.<br>than  | Ĕ              | Elementary/Secondary (0-12) College (1-4or 5+)   | binet Worker  | - /                                      | ala noto                           | ^1 /   |
|        | ල<br>ප        | filed withi<br>Hygiene.<br>other ther   |                | 17. Father's Name (First, Middle, Last)  | 18. Mother's Name (   |  | en Sumame)                         | 4.   |
| 1      | an            | d be<br>antal   | o Be           | HEDRY LETON HOURS, SA  | Marti   | 4 -                                      |                                    | 1  |
| 5      | Maryland      | d 2 should be filed within 72 ho<br>th and Mental Hygiene.<br>77 is marked other than "natur<br>traumatic event, the Medical                    | 은              |  | Address (Street and Number or Rural)  | Route Number, City                       | v or Town, State, Zip              | Code)  |
| 7      | <b>∑</b>      | nd 2 s<br>lith ar<br>27 is<br>r trau  | 11.3           | 221  | King Aethur Circle  | 0  |                                    | nd 2/237                                       |
| ナ      | ģ             | Hear<br>Hear<br>the   |                | 20a Method of Disposition 20b. Place of Dispos   | ition (Nahib of Da  | te 20c.                                  | Location - City or To              | own, State                                     |
| 7      | <u>o</u>      | 0 0 = =   |                | THANKURIA 2   ICremation 3   IHemoval from State   | atory or other place)   | 2 2004 0                                 | Wall on                            | control  |
| - (    | altimor       |   |                | 21. Signature / Funeral Service Lic , 2 ee 22.   | Ceruetery Dec. 29 Name and Address of Facility Evos                                       | accidence                                | ekville, Me                        | RYIGIN   |
| 2      | Ba            | permit. Departr importa eny init  |                |  | 100 Harford Road A  |  |                                    |  |
|        |               |   |                | 23a. Part1. Enter the disease, of complications that caused the death. Do not enter shock, or heart failure. List only the cause on Jach line. | r the mode of dving, such as cardiac or   | respiratory arrest.                      | Margiani                           | Approximate                                    |
|        |               |   |                | shock, or heart failure. List on yone cause on lach line. Immediate Cause (Final   | W 00 0  |  |                                    | Interval Between<br>Onset and Death            |
| •      |               | Physician /<br>/Medical   |                | disease or condition resulting in death)  Due to (or as a consequence of):   | Peruthelisman   |  |                                    | Peu your                                       |
|        | 1             | Examiner  |                | Due to (of as 1 consequence of).   |   |  |                                    | ***  |
|        | Çey.          |   | ē              | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying   |   |  |                                    |  |
|        | W             | d<br>ansit  | E I            | cause, Enter Underlying Cause (Disease or injury that initiated events  c.   |   |  |                                    |  |
| न ७५५० | J.            | ate be executed hysician and the burial-transit   | Examiner       | resulting in death) Last Due to (or as a consequence of):  |   |  |                                    |  |
| 9      | 68760,        | e be<br>rsicia<br>e bur   | dicai          | <b>L</b> d   |   |  |                                    |  |
| 7      | 89            |   | edi            |  |   |  |                                    |  |
| 8      | XO            | feath certifica<br>attending pt<br>d for use as t   | N N            | IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy  | <b>-</b>  |  | 23d. Date of delive                | ery  |
| M300   | m             | death certific<br>e attending p<br>od for use as  | Physician/Me   | 1 Ves 2 No. 4 Pregnant at time of death 5  | Ectopic pregnancy Other (specify)   |  | Month                              | Day Year                                       |
|        | 0             | by the  | hys            | 9 Unknown  |   |  |                                    |  |
|        | S, D          | requires that lhe de<br>een signed by the a   | by P           | Part II. Other significant conditions contributing to death but not resulting in the un  | derlying cause given in Part I.   | 23e. Did tobacc                          | o use contribute to th             | ne cause of death?                             |
|        |               | w require<br>been sig<br>should b   |                |  |   | 1 🗌 Yes                                  | 2 No 3 Prob                        | pably 4 Ashknown                               |
|        | Record        | ~ Q 70  | Completed      |  |   | 24a. Was an                              | 24b. Were auto                     | psy findings available<br>mpletion of cause of |
|        |               | The law<br>ate has<br>page 2:   | E              |  |   | autopsy<br>performed?                    | death?                             |  |
| 5      | Vital         | ician: Th<br>certificate<br>rector, pag   | a l            | 25. Was case referred to medical   | 26. Place of Death  | 111                                      | Vo 1 □ Yes                         | 2   140  |
|        |               | Physician: The l<br>this certificate har<br>ral director, page  | ToB            | examiner? 1 Yes 2 No Hospital: 1 Impatient 2 ER/Outpatient   | Othor   |  | 6 ☐Other (Specifi                  | iv)  |
| 2      | of            | g Phys<br>er this<br>eral di  |                | 27. Manner of Death 28a. Date of Injury 28b. Time of   |   | d. Describe how in                       |                                    | ,,   |
| 1      | 0             | ath.<br>r: Aft  | atio           | tatural 5 ☐ Pending (Month, Day Year) Injury 2 ☐ Accident investigation  | M 1 Yes 2 No  |  |                                    |  |
| 0)     | Division      | l or Attendi<br>after death<br>Director: A  | Hic            | 3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of Injury - At home, farm, stre building, etc. (Specify)                     | et, factory, office 28  | f. Location (Street<br>City or Town, Sta | and Number or Rura                 | al Route Number,                               |
| aver   | ō             | s afte  | Certification: | bullating, old. (optionly)   |   | Ony or 7 onn, On                         |                                    |  |
| 工      |               | Hospital or Attending<br>24 hours after death.<br>Funeral Director: After<br>tely filled in by the fune   |                | 29a. Certifier Check only 2 Medical Exeminer: On the basis of examination and/or inv   | occurred at the time, date and place, an  | d due to the cause                       | (s) and manner as st               | tated.   |
|        |               | To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral              | edical         | one) and manner stated.  | astigation, in my opinion, death occurred   | at the time, date a                      | ind place, and due to              | o ine cause(s)                                 |
|        |               | To the vithin 2 To the complet  | Σ              | 29b. Signature and title opcertifier   | 29c. License number   |  | Date signed (Month,                |  |
| T      |               | •   |                | Mandia Kroher MD   | 1150040   | /  | 2-24-2                             | 005  |
|        |               | \0  |                | 30. Name and address of person who completed cause of death (Item 23a) (Type, F  |   | 4.45                                     | 1040                               |  |
|        |               | Ψ   |                | 1308 Business later Way # 10   | L ; Edgewood  | 1111                                     | 1040                               |  |
|        |               | Sta   |                | 31. Date filed (Month, Day, Year)  32. Registrar's Signature   |   |  |                                    |  |
|        | A.            | Registr   | ar             | DEC 2 7 2005 Here & American   | R)  |  |                                    |  |

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene O C

|            |   |                  | 1 - For<br>State<br>Registrar  | State of Mary                                  |  | rtificate of   |                       |   | g. No.        | 15            | 416                           | 90           |
|------------|---|------------------|--|--|--|--|-----------------------|---|---------------|---------------|-------------------------------|--------------|
|            | Physici   |                  | Decedent's Name (First, Middle, Last)     BERNARD ALBERT HYS                       |  |  |  |                       | 2. Date of Death<br>Month<br>DECEMBER   | Day           | Year          | 3. Time o                     | of Death     |
| ):         | /Medio<br>Examir  |                  | 4a. Facility Name (If not institution, give s                                      |  |  | 4b. City, Town,  | or Location of Dea    |   |               | ty of Death   | 2:30                          | A            |
|            |   |                  | MARINER HEALTH   |  |  | GLEN BI  | JRNIE                 |   | ANNE          | ARUND         | EL                            |              |
|            | Funeral   |                  | 5. Social Security Number 6. Sex   |  | yrs. last birthday)                                      | If Under 1 Yea<br>Months Days                              | r If Under 24 Hr      |   |               |               | place (State                  | or Foreign   |
|            | Director  |                  |  | M 2□ F X 5                                     | 4 Yrs.   | Midital Bay  | 110413                | FEB 7, 1                                |               | 000           | MD                            |              |
|            | and w   |                  | Usual Residence of Decedent  10a. State 10b. County                                | 10c  | City, Town or Lo   | cation   |                       |   |               | 1             | Od. Inside C                  | City Limits  |
|            | Mary  | Į                | MD ANNIE AD  | IDDEI  | PDMD AT P  |  |                       |   |               |               |                               | s 2∏No<br>XX |
|            | 1 the   | rec              | MD ANNE AR  10e. Street and Number   | UNDEL  | ERNDALE  | 10f. Zip Code  |                       | 10                                      | g. Citizen of | What Cour     |                               | XX           |
|            | h with  | aiD              | 107 WELLS AVE  |  |  | 21061  |                       |   | T             | ISA           |                               |              |
|            | s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. Item 27 Ie marked other than "natural", or Items 23s or 28s-f show other traumatic event, the Medical Examinar must be notified at | Funeral Director | T  | 12. Was Decedent Ever i                        | n U.S. 13.   |  | Hispanic Origin? (    | Specify Yes or No-<br>irto Rican, etc.) | 14. Ra        | ce - Americ   |                               |              |
| 36         | s afte  | y Fu             | 1 Never Married 2 Married  | YYes 2 □ No<br>if Yes, Give                    | 1  | 1 ☐ Yes _2 ☐ No  |                       | nto moan, etc.,                         | Speci         | ack, White,   | etc.                          |              |
| 21215-0036 | hours<br>tural'   | ed by            | 3 ☐ Widowed ★★ Divorced  | Year or Dates:                                 |  | XX   |                       |   |               | WHI           |                               |              |
| 5          | in 72   | Completed        | 15. Decedent's Educ<br>(Specify only highest grade                                 | completed)                                     | (Give  | dent's Usual Occi<br>kind of work doni<br>DO NOT use retir | during most of w      | orking 1                                | 6b. Kind of f | Business/In   | dustry                        |              |
| 77         | with<br>iene.   | omp              | Elementary/Secondary (0-12)  | College (1-4or 5+)                             |  | PRINTEI  | •                     |   | DDTK          | TING          |                               |              |
| ਰੂ         | Hygid<br>other  | BeC              | 17. Father's Name (First, Middle, Last)  |  |  | TKINIL   | 7                     | ame (First, Middle, M                   |               |               |                               |              |
| Maryland   | Aental rked o   | To B             | THOMAS WOODROW HYS   | ELL  |  |  | ANNA MA               | Y SCHROEN                               |               |               |                               |              |
| a          | should<br>and Men<br>e marke  |                  | 19a. Informant's Name/Relationship (Typ  | oe, Print)                                     | 19b. Mailir  | ng Address (Stree  | and Number or F       | Rural Route Number,                     | City or Town  | , State, Zip  | Code)                         |              |
|            | and 2<br>ealth<br>n 27  |                  | FRANCES C. BERG  | AUNT   | 908 M  | EADOWBRO   | OOK RD GI             | EN BURNIE                               | , MD 2        | 1061          |                               |              |
| ore        | T Item  |                  | 20a. Method of Disposition 1 ☐ Burial 2 ☐ Gremation 3 ☐ Re                         |  | <ul> <li>b. Place of Dispo<br/>cemetery, crer</li> </ul> | sition (Name of<br>natory or other pl                      | ace)                  | Date 2                                  | Oc. Location  | - City or To  | wn, State                     |              |
| Ē          | Pag<br>ment<br>tant:<br>jury  |                  | 1 ☐ Burial 2 ☐ Gremation 3 ☐ Re<br>4 ☐ Donation 5 ☐ Other (Specify)                | -  | AYVIEW C   | REMATORY   | INC 12.               | 23.2005                                 | BALTIM        | ORE,          | MD                            |              |
| Baltimore, | permit. Pages<br>Department of<br>Important: If It<br>any Injury or o   |                  | 21. Signature of Funeral Service Licens  |  | FÎ<br>8 42   | NK FUNES<br>6 CRAIN  | KAL HOME,<br>HWY SW G | P.A.<br>LEN BURNIE                      | C. MD         | 21061         |                               |              |
|            |   |                  | 23a. Part1. Enter the disease, or complic<br>shock, or heart failure. List only on |  |  |  |                       |   |               | 21001         | Approxima<br>Interval Ber     |              |
| 1          | Physician   |                  | Immediate Cause (Final disease or condition  | Carcinon                                       | -4-0   | u F  |                       |   |               |               | Onset and                     | Death        |
|            | /Medical  |                  | resulting in death)  | Due to (or as a con                            |  | 4/   |                       |   |               |               |                               |              |
|            | Examiner  |                  | Sequentially list conditions, b  |  |  |  |                       |   |               |               |                               |              |
|            | art sit   | ine              | day Isacing to in reclaic cause. Enter Underlying Cause (Disease or injury         | Due to (or as a con                            | secuanda of):  |  |                       |   |               |               |                               |              |
|            | and<br>and<br>Il-tran   | Examiner         | that initiated events c. resulting in death) Last                                  | Due to (or as a con                            | sequence of):  |  |                       |   |               |               |                               |              |
| 68760,     | death certificate be executed<br>e attending physicien and<br>ad for use as the burial-transit  |                  |  | 020 10 (0: 20 2 00)                            | 334331133 31).   |  |                       |   |               |               |                               |              |
| 28         | rtificate<br>ng phys<br>as the  | Aedical          | 0  |  |  |  |                       |   |               |               |                               |              |
| ROX        | eath certi<br>attending<br>I for use a  | M/               | IF FEMALE: 23b. Was decedent pregnant  | 3c. If yes, outcome of pre                     |  |  |                       |   | 23d. Da       | ate of delive | nv.                           |              |
| ň          | death<br>e atte   | Physician/       | in the past 12 months?<br>1 ☐ Yes 2 🖪 No   | 1 Live birth 2 ☐ F<br>4 ☐ Pregnant at time     |  | Ectopic pregnand<br>Other (specify) _                      | су                    |   |               |               |                               | Year         |
| л<br>Э     | at the<br>by th<br>tache  | hys              | 9 Unknown  | 9□ Unknown                                     | -  |  |                       |   |               |               |                               |              |
| _          | law requires that the de<br>es been signed by the a<br>2 should be detached f   | by               | Part II. Other significant conditions conf   | tributing to death but not                     | resulting in the ur                                      | nderlying cause g  | iven in Part I.       | 23e. Did toba                           |               |               |                               | ,            |
| ecords,    | w requir<br>been si<br>should I   | ted              |  |  |  |  |                       | 1 Tes                                   | 2 □ No        | 3 Prob        | abiy 4 ∭⊠i                    | Jnknown      |
| Ö          | alaw<br>desb<br>fe 2 st   | Completed        |  |  |  |  |                       | 24a. Was an autopsy                     | 24b.          | Were autop    | osy findings<br>npletion of c | available    |
| ř          | : The<br>cete h   | S                |  |  |  |  |                       | performe<br>1 ☐ Yes 2                   | ed?<br>Ze No  | death?        | 20 <b>2</b> No                |              |
| VITal      | Physician: The law<br>this certificete hes l<br>ral director, page 2 s  | Be               | 25. Was case referred to medical examiner?   | ospital:                                       |  | 0  |                       | ath Check only one                      |               |               |                               |              |
| ō          | T = 6   | <u>۲</u>         | 1 ☐ Yes 2 M No   | 1 □ Inpatient                                  | 2 ☐ ER/Outpatien<br>28b. Time of                         | 1 3□ DOA   | 4 Nursing             | Home 5 ☐ Residen                        | ce 6 □Otl     | ner (Specify  | ')                            |              |
|            | ing<br>After  | ţ                | 1 X Natural 5 ☐ Pending  | 28a. Date of Injury<br>(Month, Day Year        | ) Injury   | 28c. Inju<br>Wo  | ork?<br>]Yes 2∐No     | 28d. Describe how                       | mjury occu    | rred          |                               |              |
| DIVISION   | after death. I Director: After  | fica             | 3 Suicide 6 Could not be   | 28e. Place of Injury - A                       | t home, farm, stre                                       |  |                       | 28f. Location (Stre                     | et and Num    | her or Rurai  | l Route Num                   | her          |
| É          | 2 9 5 5   | Certification:   | 4 Homicide determined  | building, etc. (Sp                             | ecify)   | ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,                    |                       | City or Town,                           | State)        |               |                               | DOI,         |
|            | To the Hospitel of within 24 hours af To the Funeral D completely filled in   |                  | 29a. Certifier 1 Certifying Phys   | ician: To the best of my                       | knowledge, death   | occurred at the t  | ime, date and plac    | e, and due to the cau                   | ise(s) and m  | anner as st   | ated.                         |              |
|            | he Hi<br>in 24<br>he Fi   | Medical          | (Check only 2 Medical Examin   | er: On the basis of exam<br>and manner stated. | ination and/or inv                                       | estigation, in my  | opinion, death occ    | urred at the time, dat                  | e and place,  | and due to    | the cause(s                   | i)           |
|            | To the Comp   | Σ                | 29b. Signature and title of certifie   |  |  |  | se number             | 290                                     | d. Date signe | d (Month, L   | Day, Year)                    |              |
| )          | $\cap$  |                  |  |  |  | 03   | 8958                  | 10                                      | 4/22          | 105           |                               |              |
|            | 4   |                  | 30. Name and address of person who cor   |  |  | Print)   |                       |   | 1             | /             |                               |              |
|            | U   |                  | · · · · · · · · · · · · · · · · · · ·  | LY CLEN BURN                                   |  | スノンン   |                       |   |               |               |                               |              |
|            | Sta<br>Registr  | _                | 31. Date filed (Month, Day, Year)  | 32 Registrar's Si                              | gnature  | we   |                       |   |               |               |                               |              |

|  |                     | For<br>Stata<br>Registrar   | State of  | Maryland / Dep<br><i>Ce</i>  | artment of He  |                          | lental Hygie                                   | 11115  | 41691  |
|--|---------------------|---|---|--|--|--------------------------|--|--|--|
| Physic<br>/Medi  |                     | 1. Decedent's Name (First, Middle Ruth  | Verna   | Hash   |  |                          | December                                       | Day Year<br>20, 2005                         | 3. Time of Death 3:20 P                            |
| Exami<br>Funeral   | ner                 | 4a. Facility Name (If not institution 3208 Philade 5. Social Security Number  | lphia Road  | oer)<br>. Age (In yrs. last birthday)                                  | 4b. City, Town, or I   | gdon<br>If Under 24 Hrs. | 8. Date of Birth                               | 4c. County of Death Harfor 9. Birth          | cd.  |
| Director   |                     | 227-14-2554  Usual Residence of Decedent  10a. State 10b. County  | 1 M 2X F  | 89 Yrs.  | Months Days  | Hours Min.               | (Month, Day, Ye<br>Mar. 15,                    | ar) Cou                                      | intry) Cginia  10d. Inside City Limits             |
| the Maryli<br>r 28a-f sho  | rector              | Maryland Harfo  |   | Abing  |  |                          | 10g.   | Citizen of What Cou                          | 1 □ Yes 2X No                                      |
| be filed within 72 hours after death with the Maryland lal Hygiene. Id Itygiene. Id other than "natural", or items 23a or 28a-f show avant, the Medical Ever must be rediffed at | by Funeral Director | 3208 Philadel  11. Marital Status  1 Never Married 2 Mar  3 Widowed 4 Divorced  | 12. Was Deced<br>Armed Forc<br>1 Tyes 2                     | [ <u>X</u> No  | 210 Was Decedent of His If Yes, specify Cuban 1 ☐ Yes 2 🖫 No                 |                          | ecify Yes or No-<br>Rican, etc.)               | USA  14. Race - Amer Black, White Specify:   |  |
| D D 2  | Completed           | 15. Deceder<br>(Specify only highe<br>Elementary/Secondary (0-12)<br>7  | nt's Education<br>st grade completed)  College (1-4         | (Give<br>life.   | dent's Usuat Occupat<br>kind of work done du<br>DO NOT use retired)<br>maker |                          | ing  | . Kind of Business/li<br>wn Home             | ndustry  |
|  | To Be               | 17. Father's Name (First, Middle, Arthur Lee  | Last)<br>Testerman  |  |  | Laura                    |  | derson                                       |  |
| 12 a   |                     | Nancy C. Mulle  |   | er 3208  | ng Address (Street ar<br>Philadelp   | ohia Rd.,                |  |  |  |
| Set  |                     | 20a. Method of Disposition 1   Burial 2 □ Cremation 4 □ Donation 9 □ Other (S   |   |  | osition (Name of<br>matory or other place)<br>Memorial (                     |                          |  | Location · City or T<br>erdeen, M            |  |
| permit. Pag<br>Department<br>Importent: I<br>any injury o  |                     | 21. Sign support free S. rvice  | vensee  |  | Name and Address<br>McComas Fu<br>1317 Cokes                                 |                          |  | on, Maryl                                    | and 21009  |
| Enysician<br>/Medical  |                     | 23a. ¶arf1. Enter the disease, or hock, or heart failure. List the timediate Cause (Finat disease or condition resulting in death)                        | a   | mentia   | er the mode of dying,  | such as cardiac o        | or respiratory arrest,                         |  | Approximate<br>Interval Between<br>Onset and Death |
| cate be executed by sicien and the buriat-transit  | dical Examiner      | Sequentially list conditions, if any, leading to immediate cause. Emar Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Due to (or   | r as a consequence of):  as a consequence of):  as a consequence of):  | Hypert   | ese<br>en sia            |  |  |  |
| he death certific<br>the attending p   | Physician/Med       | tF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes  No   |   | h 2 ☐ Fetal death 3 ☐<br>nt at time of death 5 ☐                       | Ectopic pregnancy Other (specify)  |                          |  | 23d. Date of deliv<br>Month                  | ery<br>Day Year                                    |
| w requires that the bear signed by should be detact  | by                  | Part tt, Other significant condition  |   | th but not resulting in the u  | nderlying cause given  | in Part I.               |  | o use contribute to t                        |  |
|  | Completed           |   |   |  |  |                          | 24a. Was an autopsy performed 1 Yes            | prior to co                                  | opsy findings available impletion of cause of      |
| I or Attending Physician: Tafter death. Director: After this certificat  | ation: To Be        | 25. Was case referred to medica examiner?  1 Yes 2 No 27. Manner of Death 1 Natural 5 Pendir 2 Accident investi   | Hospital: 1 Inp   | patient 2 ER/Outpatier Injury 28b. Time or Injury Injury               | other  3 DOA  Other  28c. Injury a Work?                                     | 4 Nursing Hor            | n Check onl one  Residence 28d. escribe how in |  | fy)  |
|  | Certification:      | 3 Suicide 6 Could 4 Homicide determ   | ined 288. Place of  | f Injury - At home, farm, str<br>, etc. <i>(Specity)</i>               | eet, factory, office   | 2                        | 28f. Location (Street<br>City or Town, Sta     |  | al Route Number,                                   |
| To the Hospital or within 24 hours afte To the Funeral Dir completely filled in  | edicai              | 29a. Certifier (Check only one) Cartifyir   | ng Physician: To the b<br>Examinar: On the bas<br>and manne | est of my knowledge, deatl<br>is of examination and/or in<br>r stated. |  |                          |  | (s) and manner as s<br>and place, and due to | stated.<br>o the cause(s)                          |
| To the Within 2 To the J   | Σ                   | 29b. Signature and le of certifie   | bestehen  |  |  | 76957                    |  | Date signed (Month,<br>2/2//208              |  |
| 3  | 1                   | 30. Name and address of person  | who completed cause   | of death (Item 23a) (Type,   | Print) Jeffr   | ey Schlu                 | ederberg<br>MD                                 | 21009  |  |
| Sta<br>Regist  |                     | 31. Date filed (Month, Day, Year) DEC 2 7 20  | 05 32. Reg  | gistrar's Signature  | P  |                          |  |  |  |

|  |   |                   | 1 - For<br>Stete<br>Registrar  | State of Ma  | arylar                |   |                          | nt of H                       |                              | and Me                     |                                | giene<br>Reg. No.        | 05                              | 41692  |
|--|---|-------------------|--|--|-----------------------|---|--------------------------|-------------------------------|------------------------------|----------------------------|--------------------------------|--------------------------|---------------------------------|--|
|  | Physici   |                   | 1. Decedent's Name (First, Middle, La<br>El rod G. He                              |  |                       |   |                          |                               |                              | 2                          | 2. Date of De<br>Month<br>12   | ath<br>Day<br>スノ         | Year<br>2003                    | 3. Time of Death                                 |
|  | /Medic<br>Examir  |                   | 4a. Facility Name (If not institution, give  |  |                       |   | 4b. Cit                  | y, Town, or                   | Location o                   | l Death                    |                                |                          | County of Dea                   |  |
|  |   | 3° 2              | Baltimore-Washing  | gton Medica  | 11 Ce                 | enter                                       | (                        | len 1                         | Burnie                       | e                          |                                | Anı                      | ne Aru                          | nde1   |
|  | Funeral   |                   | 5. Social Security Number 6. S   |  |                       | last birthday)                              |                          | er 1 Year                     | Il Under 2<br>Hours          |                            | B. Date of Bir<br>(Month, Da   | th<br>v. Year)           | 9. Bir                          | thplace (State or Foreign ountry) Lingin Island  |
| * <del>3</del> 2.  | Director  |                   | 580-03-3546  | 6  | 54                    | Yrs.  |                          |                               |                              | Dec                        | ember                          | 22,                      | 1940 V:                         | irgin Island                                     |
|  | and *   |                   | Usual Residence of Decedent  10a, State 10b, County                                | -  | 10c. Ci               | ty, Town or Lo                              | ocation                  |                               |                              |                            |                                |                          |                                 | 10d. Inside City Limits                          |
|  | Aaryii<br>Faho  | ō                 | Maryland Baltimo   | ore  |                       | andalls                                     |                          | 1                             |                              |                            |                                |                          |                                 | 1 ☐ Yes 2 ☐ No                                   |
|  | 28a-  | Director          | 10e, Street and Number   |  |                       |   | -                        | ip Code                       |                              |                            |                                | 10a, Citiz               | en of What C                    |  |
|  | 72 hours after death with the Maryland<br>natural', or items 23a or 28s-f show<br>disal Examinat must be nutilisal at | 0                 | 4113 Holbrook Ro   | ad   |                       |   |                          | ,                             |                              |                            |                                |                          |                                 |  |
|  | res 2;  | Funeral           | 11. Marital Status   | 12. Was Decedent I   | Ever in U             | J.S. 13.                                    | Was Dec                  | 21133<br>edent of Hi          |                              | gin? (Spec                 | ify Yes or No<br>ican, etc.)   | ited                     | 4. Race - Am                    |  |
| 10   | r Her   | 臣                 | 1 Never Married  Married   | Armed Forces?  1  Yes 2  | чo                    | 1   |                          |                               |                              | , Puerto R                 | ican, etc.)                    | 1                        | Black, Whi                      |  |
| 93   | al', o  | by                | 3 ☐ Widowed 4 ☐ Divorced   | If Yes, Give Year or Dates:  |                       |   | 1 ∐ Yes                  | 2 <b>X</b> No                 | Specify:                     |                            |                                |                          |                                 | rician<br>ican                                   |
| 21215-0036   | d within 72 hours after der<br>piene.<br>r than "natural", or fterna<br>tha Medical Examiner m                        | Completed         | 15. Decedent's E<br>(Specify only highest gro                                      |  |                       | 16a, Dece                                   | dent's Us                | ual Occupa                    | ation<br>during most         | of working                 | 7                              | 16b. Kin                 | d of Business                   |  |
| 21   | 9   | nple.             | Elementary/Secondary (0-12)  | College (1-4or 5   | i+)                   | life.                                       | DO NOT                   | use retired                   | )                            |                            |                                |                          |                                 | orioles  |
| 2  |   | So                | 12   | 0  |                       | Profes                                      | sion                     | ат ва                         |                              |                            |                                |                          | Baseba1                         | 1  |
| nd   | d a la  | Be                | 17. Father's Name (First, Middle, Last   |  |                       |   |                          |                               | 18. Mothe                    | r's Name (                 | First, Middle,                 | Maiden S                 | Sumame)                         |  |
| yla  |   | 은                 | Arthur Hendri  |  |                       |   |                          |                               |                              |                            | Callen                         |                          |                                 |  |
| Maryland   | 0 0 0 0   | 0 2               | 19a. Informant's Name/Relationship   | **   |                       |   | -                        |                               |                              |                            |                                |                          | Town, State,                    |  |
|  | an<br>n 2<br>n 2  |                   | Mrs. Merle Hendr   | icks (Spo  |                       |   |                          |                               | Road,                        |                            |                                |                          |                                 | d 21133  |
| altimore,  | of of   |                   | 20a. Method of Disposition 1 Durial 2 Cremation 3 D                                | Removal from State   | 1000                  | Place of Dispo<br>cemetery, crea<br>:ro Cre | matory or                | other plac                    | e)                           | Da                         |                                |                          | ation - City or                 |  |
| Ë  | Fant:   |                   | 4 Donation 5 Other (Speci  |  | FAEL                  |   |                          | -                             | 1                            | 2-24                       |                                |                          |                                 | MD 21229   |
| Ball   | permit. Pag<br>Department<br>Important: I<br>any Injury o<br>once.  |                   | 21. Signature of Funeral Service Lice  Joseph J Kel                                | ener   |                       |   |                          |                               |                              |                            |                                |                          |                                 | Directors<br>land 21133                          |
| 100  |   |                   | 23a. Part1. Enter the disease, or com<br>shock, or heart lailure. List only        | plications that caused   | the dea               | th. Do not ent                              | er the mo                | ode of dyin                   | g, such as                   | cardiac or                 | respiratory ai                 | rrest,                   |                                 | Approximate<br>Interval Between                  |
|  | Physician :   |                   | Immediate Cause (Final disease or condition  |  |                       |   |                          | 4.0.1                         | 10.                          |                            |                                |                          |                                 | Onset and Death                                  |
|  | /Medical  |                   | resulting in death)  | a. Arrhy<br>Due to (or as  | a consec              | quence of):                                 | ient                     | no                            | ur .                         |                            |                                |                          |                                 | IMMEDIATE  |
| 118  | Examiner  |                   | Consentation for a sufficient  | b Amulo  | olde                  | 2513  |                          |                               |                              |                            |                                |                          |                                 | 7 42013  |
|  |   | ner               | Requestially list conditions, if any, leading to immediate cause. Enter Underlying | Due to lor as  | a consec              | quence of):                                 |                          |                               |                              |                            |                                |                          |                                 |  |
|  | be executed<br>sicien and<br>burial-transit   | Examine           | that initiated events  | c  |                       |   |                          |                               |                              |                            |                                |                          |                                 |  |
| oʻ   | e exe   |                   | resulting in death) Last   | Due to (or as  | a consec              | quence of):                                 |                          |                               |                              |                            |                                |                          |                                 |  |
| 8760,  | ate be<br>hysici  | ca                |  | d  |                       |   |                          |                               |                              |                            |                                |                          |                                 | _  |
| 39   |   | Physician/Medical | IF FEMALE:   |  |                       |   |                          |                               |                              |                            |                                |                          |                                 |  |
| Вох  | eath certific<br>attending p<br>for use as  | an/               | 23b. Was decedent pregnant in the past 12 months?                                  | 23c. If yes, outcome<br>1□Live birth                                 |                       |   | Ectopic                  | pregnancy                     |                              |                            |                                | 23                       | 3d. Date of de<br>Month         | livery<br>Day Year                               |
| O. E   | e dea   | sici              | 1 Yes 2 No   | 4☐Pregnant at<br>9☐ Unknown  | time of o             | death 5                                     | Other (                  | specify)                      |                              |                            |                                |                          | MOUTH                           | Day 19a1   |
| P.0  | law requires that the de<br>as been signed by the<br>2 should be detached   | Phy               |  |  |                       | 100 - 100                                   |                          |                               |                              |                            | 00- Did.                       |                          |                                 |  |
|  | res tha<br>igned l<br>be det  | b                 | Part II. Other significant conditions  | contributing to death bi   | ut not res            | suiting in the u                            | naeriying                | cause give                    | en in Paπ I.                 |                            |                                |                          |                                 | o the cause of death?                            |
| ord  | w requir<br>been s<br>should  | ted               |  |  |                       |   |                          |                               |                              |                            | 101                            | Yes 2 🛦                  | 7No 3   P                       | robably 4 Unknown                                |
| ec   | e law<br>has b  | ple               |  |  |                       |   |                          |                               |                              |                            | 24a. Was                       |                          | prior to                        | utopsy lindings available completion of cause of |
| Vital Records,   | Th<br>ate<br>pag  | Completed         |  |  |                       |   |                          |                               |                              |                            | perfo<br>1 ☐ Yes               | rmed?<br>2.□No           | death?<br>1 ☐ Yes               | 2 No   |
| /ita   | Physician:<br>this certificant  | Be                | 25. Was case referred medical examiner?  |  |                       |   |                          |                               |                              | of Death (                 | Check only o                   | ne)                      |                                 |  |
| of \   | Physic<br>this c  | 2                 | 1 ☐ Yes 2 ☑ No   | Hospital: 1 Inpatie  |                       | ER/Outpatier                                |                          |                               | 4 🗀 1901                     | rsing Home                 | e 5 ☐ Resid                    | dence 6                  | □Other (Spe                     | ecify)   |
|  | ding P.<br>J.<br>After i  | on:               | 27. Manner of Death 1 Matural 5 ☐ Pending  | 28a. Date of Injui<br>(Month, Da)                                    | ry<br>v Ye <i>ar)</i> | 28b. Time o<br>Injury                       |                          | 28c. Injury<br>Work           |                              |                            | d. Describe I                  | now injury               | occurred                        |  |
| sio  | ten<br>leatl<br>tor:<br>the   | cat               | 2 Accident investigation 3 Suicide 6 Could not be                                  |  |                       |   | М                        |                               | Yes 2 1                      |                            |                                |                          |                                 |  |
| Division   | if or Attend<br>after death<br>Director: /  | Certification:    | 4 Homicide determined  | 28e. Place of Inju-<br>building, etc                                 |                       |   | reet, facto              | ory, office                   |                              | 28                         | II. Location (S<br>City or Tox |                          | Number or R                     | ural Route Number,                               |
|  | urs al<br>urs al<br>urs al<br>led i   |                   | - C17  |  |                       |   |                          |                               |                              |                            |                                |                          |                                 |  |
|  | To the Hospital or At within 24 hours after d To the Funeral Direct completely filled in by                           | edical            | 29a. Certifier 1 Certifying Pl<br>(Check only 2 Medical Examone)                   | nysician: To the best of<br>miner: On the basis of<br>and manner sta | examina               | owledge, deat<br>ation and/or in            | h occurre<br>vestigation | d at the time<br>on, in my or | ne, date and<br>pinion, deat | d place, an<br>th occurred | d due to the                   | cause(s) a<br>date and p | and manner a:<br>place, and due | s stated.<br>e to the cause(s)                   |
|  | ithin (   | Med               | 29b. Signature and title of certifier  | and manner sta   | ated.                 |   | 2                        | 9c. License                   | number                       |                            |                                | 29d. Date                | signed (Mon                     | th, Day, Year)                                   |
|  | T × S   |                   | Aton Ga  | steel  | 7                     |   |                          |                               | 3688                         | 5                          |                                | 1                        | 2/22/                           |  |
| •  | · h   |                   | so Hamani de   | eur, M   |                       |   | D-1 -2                   | "/                            |                              |                            |                                |                          | 7-7                             |  |
|  | 10  |                   | 30. Name and address of person who 22 S. G/ee.                                     |  |                       | m 23a) (Type,<br>9 / + 1 m c                |                          | 111                           | ) _                          | 217                        | 01                             |                          |                                 |  |
| 100  | Sta   | a to              | 31. Date filed (Month, Day, Year)  | \$2. Registra  | ar's Sign             | ature 🚣                                     | 10.                      | 11/                           |                              |                            |                                |                          |                                 |  |
| A Section of the Sect | Regist  |                   | DEC 2 7 2UU  | 52. Registra   | . 1                   | · popul                                     |                          |                               |                              |                            |                                |                          |                                 |  |

Amend item#8, perFH G850, 12-27-05 TT State of Maryland / Department of Health and Mental Hygiene For State Ragistrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Year ALUNE JACKSON 20:30 M HORTON 12 20 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MOSPITAL SAINT AGNES BALTIMORE NIA | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | (Month, Day, Year) 9. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days 1 ☐ M 2 🗷 F 247.56.6180 Yrs. <del>&</del> 5-11-1935 Director 70 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location in than "naturel", or itema 23a or 28a-f show the Medical Exeminar must be notified at 10d. Inside City Limits MD NIA 1 XYes 2 No Directo BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? RIGGS AVENUE 2206 21216 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 MM No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 20-No þ Specify: BLACK 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER 121H GRADE DOMESTIC NA 17. Father's Name (First, Middle, Last) . Pages 1 and 2 should be fil tment of Health and Mental H tent: If Item 27 Is marked otl 18. Mother's Name (First, Middle, Maiden Sumame) LUCIUS JACKSON ဂ္ DELLA KETTER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) HORTON HUSBAND) 2206 RIGGS AVE., BALTO. MD HAROLD 21216 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 6 Department of Importent: If any injury or once. 4 ☐ Donation 5 ☐ Other (Specify) ARBUIUS 12.27.05 BALTIMORE 22. Name and Address of Facility
VAUGHN C. GREENE FUNERAL SERVICE
5151 BALTO. NATU PIKE, BALTO. MO 21229 21. Signa ure of Euneral Service Literates Laughn 23a. Part1. Each the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Retween Onset and Death Immediate Cause (Final PUEDMONIA **Physician** disease or condition 14 days resulting in death) /Medical Due to (or as a consequence of): Examiner 14 clays UTI Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) attending physician and for use as the burlal-transit certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4□ Pregnant at time of death 5 Cther (specify) 1 ☐ Yes 1 2 ☐ No 9 ☐ Unknown been signed by the s Ö 9 Unknown ď Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Vital Records, Completed by ISCHEMIC CARDIOMYOPATRY 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown PHEUMATOID ARTHRITIS 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2☐ No 24a. Was an this certificate has al director, page 2 autopsy performed? 1 Yes 2 No funeral director Be 25. Was case referred to medical examiner? 26. Place of Death | Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To Inpatient 2 ER/Outpatient 3 DOA Division of 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation **У** □ Natural death. 1 ☐ Yes 2 ☐ No To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fo 2 Accident the 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2000 P 19515 M.D. 12.20, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BUCH DR KETURKUMAR 900 S.CATONAVE, BALTIMORE MD 21229 2005 Regultrar's Signature 31. Date filed (Month, DECC)2 State Been Registrar

10270r

Columbus Hundley State of Maryland / Department of Health and Mental Hygierie 5 to 12/28/05 CE Per FH G850 12/28/05 CE CERTIFICATE OF DEATH Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 12, **Physician** Month 2005 COLUMBUS December HUNDLEY 11:30 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 507 Allendale Street Baltimore n/a If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number Funeral 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 01 - 22 · 1920 Birthplace (State or Foreign Country) 1**Ø**M 2□ F Director 214-10-0491 85 Yrs MŊ Usual Residence of Decedent Maryland 10a State 10h Counts 10c. City, Town or Location rthen "neturel", or items 23s or 28s-f ehow the Mudical Examiner must be notified at 10d. Inside City Limits Director MD NIA BALTIMORE 1⊠Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 507 ALLENDALE STREET 21229 LISA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. filed within 72 hours after 1 Never Married 2 Married 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Ā Specify: Specify: BLACK 3 Nidowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) CAMPUS POLICE 121H GRADE UNIV. OF MD. NIA 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Sumame) Pages 1 and 2 should be CHARLES HUNDLEY MARY GOODE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2: Department of Health a Importent: If Item 27 le any injury or other trau once. NEPHEW) 6929 BLANCHE RD. BALTO. MD 21215 WILLIAM JOHNSON 20b. Place of Disposition (Name of cemetery, crematory or other place)

AD NATL FOREST 20a. Method of Disposition 12-28-05 OWINES MILES. MD 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 12-23-05 LAUREL. 21. Sign ture of Fur@ral Service Licensee VAUGHN C. GREENE FUNERAL SERVICE augh 5151 BALTO. NATL' PIKE, BALTO. MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** a HYPERTENSINE ATMEROSCUERITIC CARDIOVASCULAR DISGAS R /Medical bue to (or as a consequence of): (OMPLICATED BY HYPOTHERMIA Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine The law requires that the death certificate be executed sician and burial-tran resulting in death) Last Due to (or as a consequence of) Box 68760 Physician/Medical attending physi IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Day Year signed by the all d be detached for 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by should t 1 ☐ Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 100 es 2 \( \times \) No 24a. Was an rector, page 2 s autopsy performed? Vital 1 Oes 2 □ No or Attending Physician: After this certific funeral director. Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Nursing Home 5 Residence 6 MOther (Specify) Certification: To 1

Yes 2 □ No Division of 28a. Date of Injury (Month, Day Year) 28b. Time of Injury Poul AD 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural SIBJECT EXPOSED TO COLD
ENJIRON MENT 5 Pending investigation death. I Director: A 1 Yes 2 No М 2 Accident FUUND 12 12/UT AOYO 6 Could not be 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 507 ALLENDACE 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide OUTSIDE within 24 hours a
To the Funerel C the Hospital UF Home SI BALTIMONE 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Add manner stated.

Add manner stated. 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) OCME December 13, 2005 30. Name and addre pleted cause of death (Item 23a) (Type, Print) Phras 111 Penn Street, Baltimore, Maryland 21201 31. Date filed (Month, Day Eyear) 2 32. Regionar's Signature

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

|                                | Funeral<br>Director   |
|--------------------------------|---|
| Baltimore, Maryland 21215-0036 | permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Itam 27 is marked other than "natural", or Itams 23a or 28a-1 show any injury or other traumatic event, it is Medical Evantiner must be redifficed and once. |

Homer Hutchison

|                            |   |                        | 1 - For<br>State<br>Registrar   | Otate of Maryland /  | Certificate of  |  |   | 2005                                | 41695   |
|----------------------------|---|------------------------|---|--|---|--|---|-------------------------------------|---|
|                            | Physici<br>/Medio   |                        | 1. Decedent's Name (First, Middle, La:<br>Homer Delbert Hutc  | •  |   |  | 2. Date of Death<br>Month<br>Dec 2                | <sup>Day</sup> 200                  | 3. Time of Death 5 11:11 PM                               |
|                            | Examir  |                        | 4a. Facility Name (If not institution, give<br>Genesis Health(  |  |   | r Location of Death<br>ston                    |   |                                     | lbot  |
|                            | Funeral<br>Director   |                        | 191-00-3009   | ex 7. Age (In yrs. last b<br>MM 2□F 87   | oirthday) If Under 1 Year<br>Months Days  | If Under 24 Hrs.<br>Hours Min.                 | 8. Date of Birth<br>(Month, Day, Y<br>January 22  | 9.<br>1918 Pe                       | Birthplace (State or Foreign<br>Country)<br>PNNSY I Vania |
|                            | e Maryland<br>a-f show<br>lifted at   | ctor                   | Usual Residence of Decedent  10a. State 10b. County  Maryland Dorchester  |  | wn or Location<br>mbridge   |  |   |                                     | 10d. Inside City Limits 1 ☐ Yes 2 🛣 No                    |
|                            | h with th   | al Dire                | 10e. Street and Number<br>5511 Bonnie Brook Road  |  | 10f. Zip Code<br>21613  |  | 10g   | . Citizen of What                   | Country?  |
| 980                        | permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23e or 28e-f show any injury or other traumatic event, I'm Medical Everties must be rectified and once. | by Funeral Director    | 11. Marital Status  1 Never Married 2 Married 3 Nover 4 Divorced  | 12. Was Decedent Ever in U.S.<br>Armed Forces?<br>1 M Yes 2 □ No<br>If Yes, Give<br>Year or Dates:       | 13. Was Decedent of H If Yes, specify Cuba 1 Yes 2 No   |  | cify Yes or No-<br>Rican, etc.)                   |                                     | merican Indian,<br>/hite, etc.<br>n <b>i t</b> e          |
| Maryland 21215-0036        | ad within 72 hogiene.<br>er than "natu<br>er than "natu"., the Medical  | Completed              | 15. Decedent's Ec<br>(Specify only highest gra<br>Elementary/Secondary (0-12)   | de completed)  | a. Decedent's Usual Occup<br>(Give kind of work done<br>life. DO NOT use retired<br>Meat Grader | oation<br>during most of workind)              | ng  | b. Kind of Busine Governmen         | ·   |
| yland                      | 12 should be filed within h and Mental Hygiene. 7 is marked other than "Iraumatic evant, the Mer  | To Be                  | 17. Father's Name (First, Middle, Last) Archibald Hutchison   |  |   | 18. Mother's Name<br>Jessie Wing               | jard  |                                     |   |
|                            | 1 and 2 sho<br>Health and<br>Iam 27 is my   |                        | 19a. Informant's Name/Relationship (<br>Dennis Hutchison/Son  | 2  | 9b. Mailing Address (Street<br>122 Kershaw Cour   | t Joppa Mar                                    |   |                                     | e, Zip Code)  |
| Baltimore,                 | Pages 1<br>nent of Hu<br>ant: If Itan<br>ury or oth   |                        | 20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3 ☐  4 ☐ Donation 5 ☐ Other (Specify   | Removal from State Parkw   | of Disposition (Name of<br>ery, crematory or other place<br>OOOL CEMETERY                       | 12/30/   |   | c. Location - City<br>Baltimore     | or Town, State<br>, Maryland                              |
| Balt                       | permit. Page<br>Department of<br>Important: If<br>any injury or<br>once.  |                        | 21. Signature of Funeral Service Licer  | en Christina L. Hilt   | ion 22. Name and Addre<br>Leonard J. R<br>5305 Hartord  | ss of Facility<br>Luck Inc<br>Road Balti       | imore Mary1                                       | and 21214                           | 1   |
|                            | Fnysician<br>/Medical<br>Examiner   | ılner                  | 23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | b.  Due to (or as a consequence)   | e of):  |  |   |                                     | Approximate Interval Between Onset and Death              |
| و8760, ح                   | intificate be executed ing physician and as the burial-transit  | Medical Examiner       | that initiated events<br>resulting in death) Last   | c. Due to (or as a consequence d.  | e of):  |  |   |                                     |   |
| O. Box                     | The law requires that the death certifica<br>tle has been signed by the attending pl<br>page Z should be detached for use as I  | Physiclan/Med          | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown   | 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal dea 4 □ Pregnant at time of death 9 □ Unknown | th 3 ☐Ectopic pregnancy<br>5 ☐ Other (specify) _  | ,  | 0 222   | 23d. Date of<br>Month               | delivery<br>Day Year                                      |
| rds, P.                    | quires that<br>n signed b<br>uld be deta  | by                     | Part II. Other significant conditions of  |  | in the underlying cause giv   | en in Part I.                                  | 23e. Did tobac                                    |                                     | e to the cause of death?  Probably 4 □Unknown             |
| Reco                       | The law requir<br>cate has been s<br>page 2 should  | Completed              |   | , ,  |   |  | 24a. Was an autopsy performer                     | d2 prior death                      |   |
| Division of Vital Records, | anding Physician:<br>ath.<br>or: After this certifica   | Certification: To Be C | 25. Was case referred to medical examiner?  1 Yes No  27. Manner of Death  1 Natural 5 Pending investigation  3 Suicide 4 Homicide Gould not be determined  | 28a. Date of Injury<br>(Month, Day Year)   |   | y at 2 No                                      | (Check only one) ne 5 Residence 18d. Describe how | e 6 Other (Sinjury occurred         |   |
| ]                          | To the Hospital or Attu<br>within 24 hours after de<br>To the Funeral Directo<br>completely filled in by th   | edical Ce              | 29a. Certifier (Check only one) Certifying Ph   | ysician: To the best of my knowled hinar: On the basis of examination a and manner stated.               | ge, death occurred at the tin<br>and/or investigation, in my o                                  | ne, date and place, a<br>pinion, death occurre | and due to the caused at the time, date           | e(s) and manner<br>and place, and c | as stated.<br>due to the cause(s)                         |
|                            | To the within To the comple   | Me                     | 29b. Signature and title of certifier   | Markey   | 29c. Licens   | e number                                       | 29d.  | Date signed (Mo                     |   |

State

31. Date filed (Month, Day, Year)

32. Registrar's Signature

DHMH 17 Rev 1/2001

Registrar

|                |   |                | For<br>State<br>Registrar  | State of Marylar  |   | irtment of F<br>tificate of i                                  |  |  | giene<br>Reg. No.           | 105  | 41696  |
|----------------|---|----------------|--|---|---|--|--|--|-----------------------------|--|--|
|                | Physici   | an             | 1. Decedent's Name (First, Middle, Last  | )   | 11                                      |  |  | 2. Date of Dea                             | ath<br>Day                  | Year   | 3. Time of Death                                   |
|                | /Medi   | cal            | 4a. Facility Name (If not institution, give  | street and number)  | the                                     | 4h City Town of  | C \( \)  T Location of Deati             | BUEND                                      | er 1                        | 2005<br>ounty of Death   | 15:47PM  |
| 1              | Examir  | ner            | The Johns H  | aprins Ho   | sptal                                   | Balt   | SIONNIE                                  | City                                       | 40. 00                      | only of Doali  |  |
|                | Funeral<br>Director   |                | 213-25-7258  | 7. Age (In yrs. 56  | last birthday)<br>Yrs.                  | If Under 1 Year<br>Months Days                                 | If Under 24 Hrs.<br>Hours Min.           | 8. Date of Birt<br>(Month, Day<br>Feb 28   | h<br>y, Year)<br>, 1949     | 9. Birth<br>Cou  | place (State or Foreign<br>ntry) unk               |
|                | yland<br>sow  |                | Usual Residence of Decedent  10a. State 10b. County  | 10c. Ci   | ty, Town or Loc                         | cation   |  |  |                             |  | 10d. Inside City Limits                            |
|                | Ba-f et   | Director       | MD   |   | Balt                                    | imore  |  |  |                             |  | 1X Yes 2 □ No                                      |
|                | with the  | Dire           | 10e. Street and Number   |   |   | 10f. Zip Code  |  |  | 10g. Citizer                | n of What Cou  | ntry?  |
|                | death<br>ma 23  | Funeral        | 3313 E. Madison S  | 12. Was Decedent Ever in U  | I.S. 13. V                              | Vas Decedent of H<br>Yes, specify Cuba                         | 21217<br>ispanic Origin? (S              | pecify Yes or No-                          | USA<br>14.                  | Race - Ameri   |  |
| 21215-0036     | be filed within 72 hours after death with the Maryland lat Hygiene. d other than "naturel", or itema 23a or 28a-1 show event. If a Mudical Exacting mast ke profiled at   | 5              | 1 Never Married 2 Married 3 Widowed 4 Divorced   | Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:                              | 1                                       | Yes, specify Cuba  | Specify:                                 | o Rican, etc.)                             |                             | Black, White,  |  |
| 15-0           | "natu   | Completed      | 15. Decedent's Edu<br>(Specify only highest grad   |   | (Give I                                 | ent's Usual Occup<br>kind of work done o<br>OO NOT use retired | during most of wor                       | <sub>king</sub> unk                        | 16b. Kind                   | of Business/Ir   | unk unk  |
| 212            | yene.   | ошо            | Elementary/Secondary (0-12) unk u  | College (1-4or 5+)<br>nk  | ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, | 0 1101 430 104100  | '/                                       |  |                             |  |  |
|                | be filed<br>tal Hygi<br>d other   | BeC            | 17. Father's Name (First, Middle, Last)  |   |   | unk  | 48. Mother's Nar                         | ne (First, Middle,                         |                             | mame)  |  |
| Maryland       |   | 2              | 19a. Informant's Name/Relationship (T)   | una Oriati  | 10h Mailin                              | g Address (Street  | and Number of C                          | Edna Asl                                   |                             | City T   | 0-7-1  |
|                |   |                | Johns Hopkins Hos  |   |   | . Wolfe  |  |  |                             | 2.1287   | Coae)  |
| Baltimore,     | Pages 1 and 2 nent of Health int: If item 27 iry or other tri   |                | 20a. Method of Disposition  1 □ Burial 2 □ Cremation 3 □ F  4 □ Donation 5 ☒ Other (Specify)         | 20b. I<br>Removal from State  | Place of Dispos                         | sition (Name of<br>patory or other place                       | 1/1                                      | Date                                       |                             | tion - City or T   | own, State   |
| Balti          | permit. Pages<br>Department of<br>Important: If if<br>eny injury or o   |                | 21. Signature of Funeral Savice Licens Ronald S  | 99 - 0 /  |   | Name and Address<br>ate Anato<br>Itimore,                      |  |  | Balt                        | imore S  | Street   |
|                | Physician   |                | 23a. Part1 Enter the disea or comp<br>shock, or heart failure. List only o<br>Immediate Cause (Final | lcations that caused the dearne cause on each line.                                   |   |  | g, such as cardiad                       | or respiratory an                          | •                           |  | Approximate<br>Interval Between<br>Onset and Death |
|                | /Medical  |                | disease or condition resulting in death)   | Due to (or as a consec  | quente of):                             | 5 (4) 1  | VIII AI                                  | KUNON                                      | 110                         |  | twe  |
|                | Examiner  | _              | Sequentially list conditions,  | b. Human I  |   | nodefi   | CLENC,                                   | A NIA                                      | CU                          |  | Month  |
|                | uted<br>d<br>ansit  | Examiner       | if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events  | 200 (0) (0) 40 4 00,,000  | 440,100 017.                            |  |  |  |                             |  |  |
| 0,             | tificate be executed<br>g physicien and<br>as the burial-transit  |                | resulting in death) Last   | Due to (or as a consec  | quence of):                             |  |  | -  |                             |  |  |
| 68760,         | cate b<br>physic<br>the bi  | edicai         |  | d   |   |  |  |  |                             |  |  |
| Box            | To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit | Physician/Me   | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown              | 23c. If yes, outcome of pregn<br>1 ☐ Live birth 2 ☐ Feta<br>4 ☐ Pregnant at time of o | al death 3 🗌                            | Ectopic pregnancy<br>Other (specify)                           |  |  | 23d                         | l. Date of deliv<br>Month                                      | ery<br>Day Year                                    |
| P.O.           | res that t<br>igned by<br>be detac  | by Ph          | Part II. Other significant conditions co   | ntributing to death but not res   | sulting in the un                       | derlying cause give  | en in Part I.                            | 23e. Did to                                | bacco use                   | contribute to t  | he cause of death?                                 |
| ords           | w require:<br>been sig<br>should b  |                |  |   |   |  |  | 1 □ Y                                      | es 2001                     | lo 3□Prot  | babły 4 ⊡Unknown                                   |
| Vital Records, | The law rate has be page 2 shi  | Completed      |  |   |   |  |  | 24a. Was a autop perfor 1 ☐ Yes            |                             | 4b. Were auto<br>prior to co<br>death?<br>1 \( \sum \text{Yes} | opsy findings available ompletion of cause of      |
| Vita           | sician: Th<br>certificate<br>rector, pag  | Be             | 25. Was case referred to medical examiner?   | Hospital:   |   | 2□ DOA Oth   | nr.                                      | th Check only or                           |                             |  |  |
| of             | ding Phys<br>h.<br>After this<br>funeral dir  | tion: To       | 1 Yes 2 No  27. Manner of Death Natural 5 Pending Accident investigation                             | 10 Spital: 1 V Inpatient 2 28a. Da - of Injury (Month, Day Year)                      | 28b. Time of<br>Injury                  | 28c. Injun   | / at                                     | ome 5 Resid                                |                             |  | fy)  |
| Division       | To the Hospital or Attendi<br>within 24 hours after death.<br>To the Funeral Director: A<br>completely filled in by the fu  | Certification; | 3 Suicide 6 Could not be determined  | 28e. Place of Injury - At h<br>building, etc. (Speci                                  | ome, farm, stre                         | eet, factory, office   |  | 28f. Location (S<br>City or Tow            |                             | lumber or Rura   | al Route Number,                                   |
|                | Hospite     24 hours     Funeral letely filler  | Medical C      | 29a. Certifier (Check only one)  | sician: To the best of my kno<br>ner: On the basis of examina<br>and manner stated.   | owledge, death<br>ation and/or inv      | occurred at the tin<br>estigation, in my of                    | ne, date and place<br>pinion, death occu | , and due to the or<br>rred at the time, o | ause(s) and<br>date and pla | d manner as s<br>ace, and due to                               | stated.<br>o the cause(s)                          |
|                | To th<br>within<br>To th<br>comp  | Me             | 29b. Signature and title of certifier  | / a1  |   | 29c. License   | number                                   |  | 29d. Date si                | igned (Month,  | Day, Year)   |
|                |   |                | 700  | oll-mo, ph  |   | 16 S   | 2-00c                                    | )  | 12-1                        | 8-20C  | 25   |
|                |   |                | 30. Name and address of person who of Topo M. KOUS, THE  | empleted cause of death (Item   | m 23a) (Type, F<br>S Hospin             | Print) TAL: 600 N  | ORTH WOLF                                | E STREET,                                  | BALTI                       | IMORE,1  | UD 21287   |
|                | Sta<br>Regist   | ate<br>rar     | 31. Date filed (Month, Day, Year) DEC 2 7 2005   | . Registrar's Sign  |   |  |  |  |                             |  |  |

|                            |  |                | 1 - For<br>Registrar   | State of M  | 1arylan                      |                                  |                       | nt of H<br><i>te of L</i>  |  | and M                     | ental Hy                             | gien<br>Reg. N       | UUU                                      | 41697  |
|----------------------------|--|----------------|--|---|------------------------------|----------------------------------|-----------------------|----------------------------|--|---------------------------|--------------------------------------|----------------------|--|--|
|                            | Physic<br>/Medi  |                | 1. Decedent's Name <i>(First, Middle, L</i><br>Sheltor   | •   | ran                          |                                  | Jone                  | s, Sr                      | •  |                           | 2. Date of De Month                  |                      | ay Year<br>2005                          | 3. Time of Death                                     |
| * 8                        | Examir   |                | 4a. Facility Name (If not institution, gi<br>445 E. 28th S   |   | t Flo                        | or                               |                       | , Town, or<br>Balti        | Location o                                   | of Death                  |                                      | 4                    | c. County of De                          |  |
| *                          | Funeral<br>Director  |                | 5. Social Security Number 6.  220-50-0952  Usual Residence of Decedent   | Sex 7. A<br>1√M 2□F   | ige (In yrs.                 | last birthday)<br>Yrs.           | If Und<br>Months      | Days                       | If Under 2<br>Hours                          | 24 Hrs.<br>Min.           | 8. Date of Bir<br>(Month, Da<br>4-26 | ay, Yea              | r) 9. Bi                                 | rthplace (State or Foreign<br>Country)  Md.          |
|                            | Maryland -f show   | tor            | 10a. State 10b. County   | NA  | 10c. Cit                     | y, Town or Lo                    | cation                | ore                        |  |                           |                                      |                      |  | 10d. Inside City Limits 1 ☑ Yes 2 ☐ No               |
|                            | or 28e   | Director       | 10e. Street and Number   |   |                              |                                  |                       | ip Code                    |  |                           |                                      | 10g. C               | itizen of What C                         | Country?   |
| 036                        | be filed within 72 hours after death with the Maryland stal Hygiene. Ind other than "natural", or itame 23a or 28e-1 show event, I're Medical Examiner must be notified at   | by Funerai     | 445 E. 28th Str<br>11. Marital Status<br>1 □ Never Married 2 □ Married<br>3 □ Widowed 4 🏋 Divorced   | 12. Was Deceden Armed Forces 1  Yes, Give Year or Dates:        | t Ever in U.<br>?<br>] No    |                                  |                       |                            | 218<br>spanic Orig<br>n, Mexican<br>Specify: | gin? (Spec<br>, Puerto F  | cify Yes or No<br>Rican, etc.)       | )-                   | USA  14. Race - Am Black, Wh  Specify: B | ite, etc.  |
| 21215-0036                 | l within 72 ho<br>iene.<br>r than "natur<br>ire Wedical  | Completed      | 15. Decedent's E<br>(Specify only highest gi<br>Elementary/Secondary (0-12)  |   | 5+)                          | life.                            | kind of w             | ork done d<br>use retired, | lurina most                                  | of workin                 | g                                    |                      | Kind of Business                         | s/Industry   |
|                            | be filed<br>tal Hygi<br>d other  | BeC            | 17. Father's Name (First, Middle, Las  | t)  |                              |                                  | <u> </u>              | 1                          | 18. Mothe                                    | r's Name                  | (First, Middle                       |                      |  |  |
| Maryland                   | should the market marke | 2              | Harold  19a. Informant's Name/Relationship   | (Type Print)  | JOı                          | nes                              | a Addra               | es (Stroot a               |  | ary                       | Franc                                |                      | or Town, State,                          | illiams  |
| Baltimore, Ma              | es 1 and 2 :<br>of Health ar<br>f item 27 is<br>r other treu   |                | Shelton Jones, J   | r. SOI  | 20b. P                       | 1                                | 26 As                 | bury                       | Aven   | ue, I                     | Baltimo<br>ate                       | ore,                 |  | 1206   |
| Ē                          | t. Pa<br>tmer<br>rtant<br>rjury  |                | 4 □ Donation → Other (Spec<br>21. Signature of Funeral Service Lice  |   | Gı                           | reenmo                           |                       |                            | s of Facility                                | 12-23                     |                                      |                      | ltimore                                  |  |
| Ã                          | Depa<br>Impo<br>any in   |                | 1 Junt   |   |                              |                                  |                       |                            | . Eas  |                           | 1101                                 | E.                   | re, Md.<br>North A                       | 21202<br>ve.   |
|                            | Physician<br>/Medical<br>Examiner  | _              | 23a. Part1. Enter the disease, or corshock, or heart failure. List on limediate Cause (Final disease or condition resulting in death)  Sequentially list conditions. | Due to (or a:   | s a consequence              | Lai-<br>uemos of):               | er the mo             | de of dying                | , such as o                                  | cardiac or                | respiratory a                        | rrest,               |  | Approximate Interval Between Onset and Death 2 years |
| 8760,                      | cate be executed<br>physicien and<br>the burial-transit  | dicai Examiner | it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last   | c. Co V Due to (or as   | s a consequ                  | A jum                            | يال.<br>الورك         | Je                         | 28K  | ore                       |                                      |                      |  | 15 years   |
| .O. Box 6                  | The law requires that the death certifi<br>ale hes been signed by the attending<br>page 2 should be detached for use as  | Physician/Me   | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown   | 23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown  | 2 🗆 Fetal                    | death 3                          | Ectopic  <br>Other (s | oregnancy<br>pecify)       |  |                           |                                      |                      | 23d. Date of de<br>Month                 | elivery<br>Day Year                                  |
| rds, P                     | w requires that<br>been signed E<br>should be deta   | <u>م</u>       | Part II. Other significant conditions  | contributing to death   | but not resu                 | ulting in the u                  | nderlying             | cause give                 | n in Part I.                                 |                           |                                      |                      |  | o the cause of death?                                |
| Division of Vital Records, | : The law re<br>cate hes ber<br>, page 2 sho   | Completed      |  |   |                              |                                  |                       | 7 L                        |  |                           | 24a. Was<br>autor<br>perfo           |                      | death?                                   | utopsy findings available completion of cause of     |
| <u> </u>                   | rsicien: Th<br>s certificate<br>lirector, pag  | To Be          | 25. Was case referred to medical examiner? 1 ☐ Yes 25 No   | Hospital: 1 ☐ Inpati  | iont 2 🗆                     | ER/Outpatien                     | t 3□ D                | Othe                       |  | =9.97                     | Check only o                         |                      | . Co.:                                   |  |
| ion of                     | Attending Physicien: or death, ector: Atter this certificity the funeral director,   |                | 27. Manner of Death  1   | 28a. Date of Inj<br>(Month, Da                                  | ury                          | 28b. Time of<br>Injury           |                       | 28c. Injury<br>Work        | 4 🗀 Nur                                      | 28                        | e 5 M Hesii<br>3d. Describe I        |                      | 6 □Other (Spe                            | ecity)   |
| Divis                      | To the Hospital or Attending Physicien: The within 24 burus eiter death, To the Funeral Director: Atter this certificate he completely filled in by the funeral director, page   | Certification: | 3 Suicide 6 Could not be determined  | 200. Place of in  | jury - At ho<br>tc. (Specify | ome, farm, str                   | eet, facto            | y, office                  |  | 28                        | Bf. Location (S<br>City or Tou       | Street a<br>wn, Stat | nd Number or R<br>e)                     | ural Route Number,                                   |
|                            | To the Hospital or A within 24 hours efter To the Funeral Directompletely filled in by   | Medicai        | 29a. Certifying P (Check only one)  Certifying P  Medical Exa  | hysicien: To the best<br>miner: On the basis of<br>and manner s | ot examinat                  | wledge, death<br>tion and/or inv | occurrer<br>estigatio | at the time<br>n, in my op | e, date and<br>inion, deatl                  | i place, ar<br>h occurred | nd due to the<br>d at the time,      | cause(s<br>date an   | s) and manner a<br>d place, and du       | s stated.<br>e to the cause(s)                       |
|                            | To T   | Σ              | 29b. Signature and title of certifier  | 10.11 -1 - 1-1  |                              | 10                               |                       | c. License                 |  | 1100                      |                                      |                      | ate signed (Moni                         |  |
| ,                          | 3  |                | 30. Name and address of person who   |   |                              |                                  |                       |                            |  |                           |                                      |                      |  | 2005   |
|                            | Sta<br>Registr   |                | 30. Name and address of person who OMRAN AWUL  31. Date filed (Month, Day, Year)  DEC 2 7 2005   |   |                              | ture                             |                       | CALL                       | ERT  | 57.                       | SUITES                               | 70                   | BALFIMO                                  | RE,MD 21218  |

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death

1. Decedent's Name (First, Middle, Last) 3. Time of Death 2073 Physician Month Year =leanor December 7,00 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Burnia Anna Baltimone Machical Washington 120 Year If Under 24 Hrs. If Under/1 8. Date of Birth (Month, Day, NOV. 5. Social Security Number 6. Sex-Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days 1 □ M 2 F Months Hours Mary Land 95 Director 215-09-6712 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits 28a-f ahow the Medical Examiner must be notified at Maryland Pasadena Anne Arundel 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö 1568 Fair View Beach Road 21122 U.S.A. 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: or items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 1 No Specify: White þ 3 ☐ Widowed 4 ☐ Divorced "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Butler Brothers Elementary/Secondary (0-12) than filed withir Hygiene. College (1-4or 5+) permit. Pages 1 and 2 should be filled with Depertment of Health and Mental Hygien important: if Itam 21 is marked other the any injury or other traumatic acceptance. Salesperson Wholesale 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Harry Jeffres Margaret Carr 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Deborah L. Meushaw (Niece) 8447 Bay Road, Pasadena, Maryland 21122 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Most Holy Redeemer 12-23-05 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility phoe MacGullyn-Rolyniak a Guneral Home Maryland 21122 2411. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause or each line. Approximate Interval Between amediate Cause (Final isease or condition resulting in death) Onset and Death neumonia Prysician /Medical (or as a consequence of) Examiner Sequentially list conditions, lary, learning to introduce cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a nonsequence of) Examine burial-transit certificate be executed and Due to (or as a consequence of) attending physicien for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy detached for Month Day Year 4□Pregnant at time of death 5 Other (specify) P.O. the 9 Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, The law requires page 2 should be 1 Yes 2 Dio 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an hes autopsy performed? Yes 2 No certificete 2 No 1 ☐ Yes 1 Yes Division of Vital r: After this certifice e funeral director, p To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifice 25. Was case referred to medical examiner? 26. Place of Death Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No ို 2 ER/Outpatient 3 DOA 28a. Dale of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28d. Describe how injury occurred Injury at Work? Certification: Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident thθ 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 Homicide tifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier and manner stated.

State Registrar

DHMH 17 Rev 1/200

31. Date filed (Month, Day, Year) 7 2005

29b. Signature and the of certifier

32 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

150 B

N

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item State of Maryland / Department of Health and Mental Hygiene 15 5 per Verb., G850 12/2//05dab Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Month Year 15 2005 give street and number) 4c. County of Death 4a Facility Name (If not institution 4b. City, Town, or Location of Death

If Under

₹. Age (In vrs. last birthday)

MORE If Under 24 Hrs.

14

10d. Inside City Limits

1224

Dav

2 \ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

BRUADWAY

BALTIMORE

29d. Date signed (Month, Day, Year)

DECEMBER 19, 2005

21205

Friend's

Approximate Interval Between Onset and Death

YEARS

1 Tes 2 No

**Physician** /Medical Examiner

Director

Be

104

5. Social Security Number

05

6. Sex

**Funeral** Director the Maryland 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If itam 27 is markad other than "natural", or Itams 23a or 28a-1 show any injury or other traumatic avant, Ita Medical Examinat must be rediffied at

altimore, Maryland 21215-0036

Box 68760

P.O.

Division of Vital Records.

**Physician** /Medical Examiner

Examiner use as the burial-transit attending physician certificate be Physician/Medical the Š þ Completed Hospital or Attending Physician: this Certification: After within 24 hours after death. To tha Funaral Diractor: A

8. Date of Birth Birthplace (State or Foreign Country) Months Hours Min. 217-03 1 □ M 2 12 Yrs. - Dodle Usual Residence of Decedent 10c. City, Town or Location 10b County 10a State 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ NeverMarried 2 ☐ Married 1 Yes 2 No Specify 3 Widowed 4 □ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) KER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame, KWOWK 19a. Informant's Name/Relationship (Type, Print, 19b. Mailing Addres Street and Number or Rural Route Number, City or Town, State, Zip Code) Date BALTO. -EE 104 20b. Place of Disposition (Name of 20a. Method of Disposition 200 Location - City or Town, State DEC 20 2005 cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State EARTOFTESUS 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Foneral Service Lioensee 22. Name and Address of Facility 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Domentia disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 100 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 - No 1 Yes 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: 1 Inpatient Other: 1 ☐ Yes 2 No 2 ER/Outpatient 4 ☐ Nursing Home 5 ☐ hesidence 6 ☐ Other (Specify) 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural Injury 5 Pending

State Registrar

31. Date filed (Month, Day, Year) DEC 2 2005

29b. Signature and title of certifier

2 Accident

3 Suicide

29a. Certifier

Medical

4 Homicide

(Check only one)

SUDNEU

investigation

6 Could not be determined

DY

32. Registrar's Signature

1200M 609

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

To the

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 Yes 2 No

1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D53590

624

|   |  |                | For State Registrar  | State of Maryland  |  | nt of Health and<br>te of Death                             |   | 005                                      | 41700  |
|---|--|----------------|--|--|--|---|---|--|--|
| -3-                                     | Physici  |                | 1. Decedent's Name (First, Middle, I   | J. Kellok  | 2  |   | 2. Date of Death                                    | 8-05                                     | 3. Time of Death                                   |
|   | /Medio<br>Examin   |                | 4a. Facility Name (If not institution, g   | ive street and number)   | 4b. City                                       | Town, or Location of De                                     | ath   | 4c. County of Dea                        | ath  |
| ÷                                       | Funeral<br>Director  | 1              | 12.58-3689   | Sex 7. Age (In yrs. las  | st birthday) It Under Months                   | er 1 Year If Under 24 H<br>Days Hours Mi                    |   | 9. Bi                                    | rthplace (State or Foreign ountry)                 |
| Z 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 | e how  | or             | Usual Residence of Decedent  10a. State 10b. County  | 10c. City,   | Town or Location                               |   |   |  | 10d. Inside City Limits 1 7es 2 No                 |
| death with the Marvland                 | a or 28a-  | Director       | 10e. Street and Number   | Road   |  | ore<br>p Code   | 10g   | Citizen of What C                        |  |
| - a                                     | teme 23  | Funeral        | 11. Marital Status  Never Married 2 ☐ Married  | 12. Was Decedent Ever in U.S. Armed Forces?  | 13. Was Dece<br>If Yes, spe                    | edent of Hispanic Origin?<br>ecify Cuban, Mexican, Pue      | (Specify Yes or No-<br>erto Rican, etc.)            | 14. Race - Am<br>Black, Whi              | erican Indian,<br>te, etc.                         |
| 5-0036                                  | atural', or  | þ              | 3 Widowed 4 □ Divorced   | If Yes, Give<br>Year or Dates:   | 1 ☐ Yes<br>16a. Decedent's Usa                 | ual Occupation  | 16  | Specify 3 1                              | ack<br>Vindustry                                   |
| Maryland 21215-0036                     | to Health and Mental Hygiene. If item 27 is marked other than "natural", or iteme 23s or 28s-f show or other traumatic event, the Medical Examinar must be notified at | Completed      | (Specify only highest of Elementary/Secondary (0-12)   | College (1-4or 5+)   | Sign bland of w<br>Pard Le                     | ork done during most of w<br>use retigion                   | rorking   | tato o                                   | FMD  |
| /land                                   | Mental Hy<br>irked oth<br>itic event   | To Be C        | 17. Father's Name (First, Middle, La   | ler  |  | 18. Mother's N  | ame (First, Middle, Ma.                             | iden Sumame)<br>Tacks                    | ON   |
| , <b>N</b>                              | salth and<br>n 27 is ma  |                | 19a. Informant's Name/Relationship Breadw Ke   | Her (Sister  | 187  | s (Street and Number or I                                   | Rural Route Number, C                               | City or Town, State,                     | Zip Code) 21234<br>Rel 1511                        |
| imore                                   | ant and  |                | 20a. Method of Disposition  1 Burial 2 Premation 3 4 Donation 5 Other (Spec  | Eliginoral from State  | te of Disposition (Na<br>netery, crematory or  | time of other place)  | Date 200  | c. Location - City or                    | Town, State  |
| Ball                                    | Departi<br>import<br>eny inj<br>spce.  |                | 21. Signature of Funeral Service Lic   | to Mol36   | 03 / 19-                                       | and Address of Facility                                     | Services  | P.A.<br>+ Belt                           | MD 2122=   |
| PI                                      | hysician   |                | 23a. Part I. Enter the disease, or co<br>shock, or heart failure. List on<br>Immediate Cause (Final<br>disease or condition                                | mplications that caused the death. by one cause on each line.                                    | Do not enter the mo                            | de of dying, such as cardi                                  | ac or respiratory arrest                            | '  | Approximate<br>Interval Between<br>Onset and Death |
|   | Medical<br>xaminer   |                | resulting in death)  | Due to (or as a consequer  | nce of):                                       | ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,                     |   |  | 1  |
| Co XX                                   | ind<br>transit   | Examiner       | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | Due to (or as a consequer  |  |   |   |  |  |
| 8760, 87                                | hysicie<br>the bur   | dicai Ex       | resulting in death) cast   | Due to (or as a consequer  | nce of):                                       |   |   |  |  |
| Box 6                                   | attending p  | an/Me          | IF FEMALE:<br>23b. Was decedent pregnant<br>in the past 12 months?   | 23c. If yes, outcome of pregnance  |  | pregnancy   |   | 23d. Date of de                          |  |
| P.O. E                                  | ed by the a<br>detached fo   | Physician/Me   | 1 ☐ Yes 2 ☐ No<br>9 ☐ Unknown  | 4 Pregnant at time of deat 9 Unknown   |  |   |   | Month                                    | Day ⁴Year  |
|   | been signed<br>should be der   | ρ              | Part II. Other significant conditions  | contributing to death but not resulti  | ng in the underlying                           | cause given in Part I.                                      | 23e. Did tobac                                      | \ .                                      | o the cause of death?                              |
| I Rec                                   | oete has b<br>page 2 st  | Completed      |  |  |  |   | 24a. Was an autopsy performed 1 Yes 2               | prior to death?                          | utopsy findings available completion of cause of   |
| of Vital                                | certificete ha   | Be             | 25. Was case referred to medical examiner? 1 ☐ Yes 2 No  | Hospital:  |  | Other   | eath Check only one                                 | 14                                       | 11   |
| lgin igi                                | death.<br>ctor: After this<br>/ the funeral di   | ation: To      | 27. Manner of Death  1 Natural 5 Pending 2 Accident investigati  | 28a. Date of Injury<br>(Month, Day Year)   | NOutpatient 3 Do                               | OA 4 Nursing<br>28c. Injury at<br>Work?<br>1 ☐ Yes 2 ☐ No   | Home 5 Residence<br>28d. Describe how               |  | city) +05 (Ce                                      |
| - i                                     | i Die  | Certification: | 3 Suicide 6 Could not<br>4 Homicide determine  | be d 28e. Place of Injury - At home building, etc. (Specify)                                     | e, farm, street, factor                        | y, office   | 281. Location (Stree<br>City or Town, S             | t and Number or Ri<br>State)             | ural Route Number,                                 |
| Did                                     | within 24 hours a<br>To the Funeral I<br>completely filled   | edical         | 29a. Certifier Check only one) Certifying F  | Physician: To the best of my knowle<br>aminer: On the basis of examination<br>and manner stated. | edge, death occurred<br>n and/or investigation | at the time, date and place<br>in, in my opinion, death occ | ce, and due to the caus<br>curred at the time, date | e(s) and manner as<br>and place, and due | s stated. to the cause(s)                          |
| To the                                  | withir<br>To th<br>comp  | Me             | 29b. Signature and titre of certifier  | Long Riles   | (m) (29  | c. License number   |   | Date signed (Mont                        | n, Day, Year)                                      |
|   | 10   |                | 30. Name d address of person wh  | o comple cause of death (Ite 23  | 3a) (Type, Print)                              | Torles St. 13   |   |  | ,  |
|   | Sta<br>Registr   |                | 31. Date filed (Month, Day, Year) DEC 2 7 200  | 32. Registrar's Signature  |  |   |   |  | M  |
| DHMH                                    | 1 17 Rev 1/20  | 001            | 500 2 1 700  | Designation of   | 1  |   |   |  |  |

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend item#20b-c.perFH.C850, 12/29/05 TT

State of Maryland Department of Health and Mental Hygiene 15 1 - For Stata Ragistrar Certificate of Death Rag. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Day Year 12 19 Zou 55 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Logation of Death 4c. County of Death **Examiner** BALTIMORE

If Under 1 Year If Under 24 Hrs. 8. Date of Birth
(Month, Day, Year) VA Medical NIA LtimoRe 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral**  Birthplace (State or Foreign
Country) -36-3270 12 M 2□F Months Director 4UG. 12,1934 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hyglene. nt: If Item 27 Is marked other than "natural", or Items 23e or 28a-f show 10a. State ir than "natural", or Items 23e or 28a-f show the Madical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1XYes 2 □ No MARYLAND 10e. Street and Number 10f. Zip Code Citizen of What Country? HEIGHTS 212 45 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 X Yes 2 □ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 21215-0036 1 Yes 2 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Specify: BLACK Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 10 THGRADE INGER traumatic event, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) EDDIE GFORD 19a. Informant's Name/Relationship (Type, Print) Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) : If item 27 lg WIFE ALVERTON HGTS. BALTO, MD. Baltimore, 20a. Method of Disposition 20b Place of Disposition (Name of Date 20c. Location - City or Town, State 1. Burial 2 Cremation 3 Removal from State Baltinorenation other place) Baltimore permit. Page Department of Importent: If any injury or once. 4 ☐ Donation 5 ☐ Other (Specify) ST 12-28-05 0 SONFORE 21. Signature of Funeral Service Licensee BROWN JR. FUNERAL HOME 22. Name and Address of Facility 2140 N. FULTON Wiano 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Sepsis /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. attending physician Be Completed by Physician/Medical as the l IF FEMALE: use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy jo in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 4☐Pregnant at time of death 5 Other (specify) detached Division of Vital Records, P.O. 9□ Unknown 9 Unknown ģ signed l Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 25 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed certificate Colon Can ce 1 ☐ Yes 2 No 1 Yes 2. No or Attending Physicien: Director: After this certific in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 1 point 2 EP/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Natural 2 Accident 5 Pending investigation Injury death. 1 ☐ Yes 2 ☐ No 3 ☐ Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) after 4 | Homicide within 24 hours a To the Funerel C 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) To the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) P19749  $n^{\chi}$ 30. Name and address of person who completed cause of death (Item 23a) (Type, Print). 140 RYAN KLENER 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 2005 Registrar Grandle J

DHMH 17 Rev 1/2001

| hysici  | 20   | Decedent's Name (First, Middle, La   |  |  |  |  | 2. Date of De  | Day  | Year   | 3. Time of Death   |
|---|--|--|--|--|--|--|--|--|--|--|
| /Media  |  | Carroll Lero   |  | ler, Jr.   | <del></del>  |  | Decem  | ber 17,  | 2005   | 5:00 A   |
| Examir  | ner  | 4a. Facility Name (If not institution, gi  |  |  |  | or Location of Dea   | th   |  | y of Death   |  |
|   |  | 741 Hookers Mill 5. Social Security Number 6.  |  | (In yrs. last birthday   | Abino  |  |  | rth  | rford<br>9. Birtho   | place (State or Forei  |
| ineral<br>rector  |  |  | <b>№</b> м 2 Г F   | 67 Yrs.  | Months Days  | Hours Mir  | . (Month, Da<br>May 2  | ay, Year)  |  | place (State or Forei<br>ptry)<br>vland  |
|   |  | Usual Residence of Decedent  |  | 40- Oh T   |  |  | · · · · · · · · · · · · · · · · · · ·  | 2, 1750  |  | •  |
| shoy  | 2  | 10a. State 10b. County   |  | 10c. City, Town or I   | Location   |  |  |  | ,  | 0d. Inside City Limi<br>1 ☐ Yes 2√21   |
| "naturel", or Items 23e or 28e-f show<br>aligal Ever ther must be notified at   | Director   | Maryland Harford 10e. Street and Number  |  | Abingdo  | 10f. Zip Code  |  |  | 10g. Citizen of  | What Cour  |  |
| 5 9 0   |  | 741 Hookers Mill   | Poad   |  | 2100   | 00   |  |  |  | My .   |
| -   | Funeral  | 11. Marital Status   | 12. Was Decedent E   | ver in U.S. 13   | . Was Decedent of H  |  | Specify Yes or No  |  | SA<br>ce - Americ  |  |
| Cultre  | Fu   | 1 ☐ Never Married 2 🔀 Married  | Armed Forces?  1  Yes 2 N  If Yes, Give  | 0  | 1 ☐ Yes 2 □ No   | an, mexican, Pue<br>Specify:   | nto Rican, etc.)   | }  | ack, White,  | etc.   |
| I Evo   | d by   | 3 Widowed 4 Divorced   | Year or Dates:   |  | 2.   |  |  | Speci  | W  | nite   |
| I've Medical  | Completed  | 15. Decedent's E<br>(Specify only highest gi   |  | (Giv   | edent's Usual Occup<br>re kind of work done<br>. DO NOT use retire   | during most of we  | orking   | 16b. Kind of E   | Business/In  | dustry   |
| The M   | шо   | Elementary/Secondary (0-12)  | College (1-4or 5-  | +)   | and Fende  |  | ni a   | Azztomol   | aila T   | Down i se  |
| event, 1  | Be C   | 17. Father's Name (First, Middle, Las  | it)  | bouy   | and rende  |  | ITC<br>ime (First, Middle  | Automol  |  | kepair   |
| 3 6   | To B   | Carroll Lero   | y Kiebl  | er, Sr.  |  | Kather   | ine v  | Virginia   | a  | Chester  |
| traumatic   |  | 19a. Informant's Name/Relationship   | (Type, Print)  | 19b. Mai   | iling Address (Street  | and Number or F  |  |  |  |  |
| er tre  |  | June Kiebler - W   | ife  |  | Hookers M  | fill Road  |  | don, Mai   | cyland   | 21009  |
| or other  |  | 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 [  | ☐Removal from State  | 20b. Place of Disp<br>cemetery, cri  | position (Name of<br>ematory or other place  | сө)  | Date   | 20c. Location  | - City or To   | own, State   |
| injury o  |  | ' 4 □ Donation 25 □ Other (Spec  | ify)   |  | Serv. Cor  |  | -19 <b>-</b> 05  | Towsor   | ı, Mai   | yland  |
| any in  |  | 21. Signature of Funeral Service Lice  | ensee  | 1  | 22. Name and Addre   | -  |  | s Funera   |  | •  |
| : 6 O   | Н  | super u  | Meigh  |  | 1317 Coke  |  |  |  | 1D 210   |  |
| ician   |  | 23a. Part1. Enter the disease, or cor<br>shock, or heart failure. List only<br>Immediate Cause (Final  | y one cause on each line   | e.   | into the mode of dy  | ig, such as caraic   | ic or respiratory a  | irest,   |  | Approximate<br>Interval Between  |
|   |  | disease or condition resulting in death)   | a  | PHYSEM   |  |  |  |  | ;  | Onset and Death  |
| ical  |  | disease or condition resulting in death)   | a  |  |  |  |  |  | 7  | Onset and Death  |
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| uneral director, page 2 should be detached for use as the burial-transit  | To Be Completed by Physician/Medical                       | disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  | Due to (or as a b.  Due to (or as a c.  Due to (or as a c.  Due to (or as a d.  23c. If yes, outcome of the contribution of th | or programmy 2 programmy 2 programmy 2 programmy 3 to not resulting in the consequence of | DEctopic pregnance Other (specify)  underlying cause give  ent 3 DOA of 28c. Injur Wor   | y<br>yen in Part I.<br>26. Place of Decer: 4 □ Nursing   | 23e. Did 1  24a. Was auto perfo 1 Tyes ath (Check only of the check on the  | 23d. Da Millon D | ate of delivered onth attribute to the stribute to the stribute autoprior to condeath?   | Onset and Death  FN YEAR  Pary Day Year  The cause of death?  The cause of death?  The cause of death of death?  The cause of death of death of death of cause of death?   |
| by the funeral director, page 2 should be detached for use as the burial-transit  | To Be Completed by Physician/Medical                       | disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  | Due to (or as a b.  Due to (or as a c.  Due to (or as a c.  Due to (or as a c.)  Due to (or as a c.)  23c. If yes, outcome of the control of  | consequence of):  a conseq | DEctopic pregnancy Other (specify)  underlying cause give  ent 3 DOA of 28c. Injur Mo 1  | y y at k?  | 23e. Did 1  24a. Was auto perfu  1  Yes  ath (Check only of the control of the co | 23d. Da Millon D | ate of delivered at the order of the order o | Onset and Death  EN YEAR  Pry Day Year  The cause of death?  The cause of death of the cause of death  The cause of death of the cause of death  The cause of death of the cause of death  The cause of death of the cause of death  The cause of death of the cause of death  The cause of death of death of death of death  The cause of death |
| u of the funeral director, page 2 should be detached for use as the burial-transit  | Certification; To Be Completed by Physician/Medical        | disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  | Due to (or as a b.  Due to (or as a c.  Due to (or as a c.  Due to (or as a c.)  Due to (or as a c.)  Due to (or as a c.)  1   | consequence of):  a conseq | Dectopic pregnancy Other (specify)  underlying cause give  ent 3 DOA of 28c. Injur M 1  street, factory, office  | y y 26. Place of Dener: 4 □ Nursing y at k? Yes  | 23e. Did to the control of the contr | 23d. Da M.  Yes 2 No san psy primed? 2 No one) idence 6 Ott how injury occur  Street and Num. wn, State)   | ate of deliver onth attribute to the stribute to the stribute to the stribute to conduct the stribute to conduct the stribute to the stribute  | Onset and Death  FN YEAR  Pry Day Year  The cause of death?  |
| u is the funeral director, page 2 should be detached for use as the burial-transit  | Certification; To Be Completed by Physician/Medical        | disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  | Due to (or as a b. Due to (or as a c. Due to (or as a c. Due to (or as a d. Due to (or as | or proyserm a consequence of): a | Dectopic pregnancy Other (specify)  underlying cause give  ent 3 DOA of 28c. Injur M 1  street, factory, office  | y y 26. Place of Dener: 4 □ Nursing y at k? Yes  | 23e. Did to the control of the contr | 23d. Da M.  Yes 2 No san psy primed? 2 No one) idence 6 Ott how injury occur  Street and Num. wn, State)   | ate of deliver onth attribute to the stribute to the stribute to the stribute to conduct the stribute to conduct the stribute to the stribute  | onset and Death  EN YEAR  Bry Day Year  The cause of death?  |
| by the funeral director, page 2 should be detached for use as the burial-transit  | To Be Completed by Physician/Medical                       | disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  | Due to (or as a b.  Due to (or as a c.  Due to (or as a c.  Due to (or as a c.)  Due to (or as a c.)  Due to (or as a c.)  1   | or proyserm a consequence of): a | Dectopic pregnancy Other (specify)  underlying cause give  ent 3 DOA of 28c. Injur M 1  street, factory, office  | y 26. Place of De ler: 4 □ Nursing yat k? Yes 25 No  | 23e. Did to the control of the contr | 23d. Da M.  Yes 2 No san psy primed? 2 No one) idence 6 Ott how injury occur  Street and Num. wn, State)   | ate of deliver onth attribute to the stribute to the stribute to the stribute to the stribute to condition to condition to condition to condition the stribute to the stribute | onset and Death  EN YEAR  Bry Day Year  The cause of death?   |
| uj in funeral director, page 2 should be detached for use as the burial-transit and a   | edical Certification; To Be Completed by Physician/Medical | disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  | Due to (or as a b. Due to (or as a c. Due to (or as a c. Due to (or as a d. Due to (or as | or proyserm a consequence of): a | Ectopic pregnancy Other (specify) underlying cause giv  and 28c. Injury M 1  street, factory, office ath occurred at the tir investigation, in my of   | 26. Place of Delection:  26. Place of Delection: 4 \( \text{Nursing} \) y at the text and place point on, death occurs on the place of the text and place point on, death occurs on the text and place of the text and place | 23e. Did 1  24a. Was auto perficulty for the perficulty of the performance of the perform | 23d. Date signes   | ate of deliver onth attribute to the stribute to the stribute to the stribute of the stribute  | Onset and Death  FIN YEAR  Bry Day Year  The cause of death?   |
| us certificate has been signed by the attending physician and director, page 2 should be detached for use as the builat-transit or as | edical Certification; To Be Completed by Physician/Medical | disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  | Due to (or as a b. Due to (or as a c. Due to (or as a c. Due to (or as a d. Due to (or as | or production of the consequence of):  a conse | Document at the time transfer of the courred at the time transfer of the course of | 26. Place of Delection:  26. Place of Delection: 4 \( \text{Nursing} \) y at the text and place point on, death occurs on the place of the text and place point on, death occurs on the text and place of the text and place | 23e. Did 1  24a. Was auto perficulty for the perficulty of the performance of the perform | 23d. Date signes   | ate of deliver onth attribute to the stribute to the stribute to the stribute of the stribute  | Onset and Death  FN YEAR  Bry Day Year  The cause of death?   |

DHMH 17 Rev 1/2001

ORIGINAL

|                     |   |                | For<br>State<br>Registrar                                       | State of                        | Maryland                                       |                        | artment of H   |                          | and Mental Hy                                     | giene 05                       | 1703                             |
|---------------------|---|----------------|---|---------------------------------|--|------------------------|--|--------------------------|---|--------------------------------|----------------------------------|
|                     | Physici   | an             | 1. Decedent's Name (First, Middle                               | , Last)                         |  |                        |  |                          | 2. Date of De<br>Month                            |                                | 3. Time of Death 8:00 A M        |
|                     | /Medic  | al             | Charles   | Hugo                            | Kiser  |                        | 4. Oh. T   | 1                        | December  |                                |                                  |
|                     | Examin  | er             | 4a. Facility Name (If not institution 3443 Carriage             |                                 |  |                        | 4b. City, Town, or Randalls  |                          |   | 4c. County of Balti            |                                  |
| ı                   | Funeral   |                | 5. Social Security Number                                       | 6. Sex 7                        | 7. Age (In yrs. I                              | ast birthday)          | If Under 1 Year_   | If Under                 | 24 Hrs. 8. Date of Bi                             |                                | Birthplace (State or Foreign     |
| ļ,                  | Director  |                | 219-30-5929 Usual Residence of Decedent                         | 1 <b>X</b> M 2□F                | 69   | Yrs.                   | Months Days  | Hours                    |   | r 11,1936                      | Maryland                         |
|                     | land<br>ow  |                | 10a. State 10b. County  |                                 | 10c. City                                      | , Town or Lo           | cation   |                          |   |                                | 10d. Inside City Limits          |
|                     | Many<br>a-f sh  | tor            | Maryland Balti  | more                            | Ran  | da11st                 | own  |                          |   |                                | 1 ☐ Yes 🌉 No                     |
|                     | or 28   | Directo        | 10e. Street and Number  |                                 |  |                        | 10f. Zip Code  |                          |   | 10g. Citizen of Wha            | at Country?                      |
|                     | ath w   | ral            | 3443 Carriage   |                                 |  |                        | 21133  |                          |   |                                | es of America                    |
|                     | ltams<br>mern   | Funeral        | 11. Marital Status 1 ☐ Never Married 2 ☑ Marr                   | Armed For                       | dent Ever in U.:<br>ces?<br>2 □ No.            | S. 13. \               | Vas Decedent of His<br>f Yes, specify Cubar  | spanic Ori<br>n, Mexicar | gin? (Specify Yes or No<br>n, Puerto Rican, etc.) | 0- 14. Race -<br>Black,        | American Indian,<br>White, etc.  |
| 2                   | urs aff   | by             | 3 Widowed 4 Divorced  | If Yes, Give                    | 9  |                        | ∏Yes 2∭ No   | Specify:                 |   | Specify:                       | White                            |
| 5                   | 72 ho   | ted            | 15. Decedent  | 's Education                    |  | 16a. Deced             | lent's Usual Occupa<br>kind of work done d   | ition                    | t of working                                      | 16b. Kind of Busin             | ness/Industry                    |
| 7                   | permit. Pages 1 and 2 should be tiled within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If itam 27 is marked other than "natural", or Itams 23a or 28a-f show any injury or other traumatic event. The Medical Examinar must be notified at an ance. | Completed      | Elementary/Secondary (0-12)                                     | College (1-                     | 4or 5+)  | life. I                | oo NOT use retired)<br>essman  | )                        | t di Hoiking                                      | Charitab!                      | e Organization                   |
| Maryland ZIZIS-0036 | filed v<br>Hygie<br>other t   | e Co           | 12 17. Father's Name (First, Middle,                            | Last)                           |  |                        |  | 18. Mothe                | er's Name (First, Middle                          | , Maiden Sumame)               |                                  |
| <u></u>             | Aental rked c   | To Be          | Ray Kiser   | :                               |  |                        |  | Mab1                     | e Berkmeie  | •                              |                                  |
| <u>a</u>            | and A<br>ls ma  |                | 19a. Informant's Name/Relations                                 |                                 |  |                        | *  |                          | er or Rural Route Numb                            |                                |                                  |
|                     | and<br>lealth<br>m 27<br>her tr   |                | Maria Kiser   | (:                              |  | and the second second  |  |                          | -   |                                | town, MD, 21133                  |
| pallillore,         | iges 1<br>nt of the if ital   |                | 20a. Method of Disposition  1 Description  2 Cremation          |                                 | naie   |                        | sition (Name of natory or other place  |                          | 12/30705  | 20c. Location - Cit            |                                  |
|                     | iit. Pa<br>artmer<br>ortant<br>njury  |                | * 4 □ Donation 5 □ Other (S)  21. Signaton of Funeral Segrote   |                                 | Gar  |                        | Forest Ve  |                          |   |                                | .11s,MD. 21117<br>1 Directors In |
| 0                   | permi<br>Depa<br>Impo<br>any is   |                | 1 Character   | Koomer 1                        | K0033  | 3 87                   | 28 Libert  | y Ro                     | ad,Randalls                                       | stown.Marv                     | land 21133                       |
| г                   |   |                | 23a. Par 1. Enter the disease, or spock, or heart failure. List | complications that ca           | used the death                                 |                        |  |                          |   |                                | Approximate<br>Interval Between  |
|                     | Physician   |                | Immediate Cause (Final disease or condition                     | iny one cause on ea             | cute   | 5                      | ontice   | 41                       | 9 '   |                                | Onset and Death                  |
|                     | /Medical  |                | resulting in death)   | aDysto (c                       | or as a consequ                                | ence of):              | 5 M  | -                        |   |                                | =                                |
|                     | Examiner  | 1              | Sequentially list conditions,                                   | b. 12                           | 196  | cfo                    | 5 M  | 0//                      | 1725  |                                |                                  |
|                     | ed sit  | ine            | cause. Enter Underlying Cause (Disease or injury                | Date to (c                      | ог на в оспажую                                | ience of):             |  |                          |   |                                |                                  |
|                     | xecut<br>and  | Examiner       | that initiated events<br>resulting in death) Last               | c<br>Due to (r                  | or as a consequ                                | ience of);             |  |                          |   |                                |                                  |
| 9/00,               | cate be executed oblysician and the burial-transit  | calE           |   | d                               |  |                        |  |                          |   |                                |                                  |
| Ď                   | tificate<br>ig phy<br>as the  |                |   |                                 |  |                        |  |                          |   |                                |                                  |
| מכא                 | th cert<br>endin<br>r use   | an/N           | IF FEMALE:<br>23b. Was decedent pregnant                        | 23c. If yes, outc               | come of pregna                                 |                        | Ectopic pregnancy  |                          |   | 23d. Date of                   | ,                                |
|                     | The law requires that the death certificate be executed to has been signed by the attending physician and bage 2 should be detached for use as the burial-transit   | Physician/Med  | in the past 12 months?  1 Yes 2 No                              |                                 | ant at time of de                              |                        | Other (specify)  |                          |   | Month                          | Day Year                         |
| 5                   | hat th<br>id by t   | Phy            | 9 ☐ Unknown  Part II, Other significant condition               | ns contributing to de           | ath but not resu                               | ilting in the u        | nderhving cause give   | n in Part I              | 23e Did   | tobacco use contribu           | ite to the cause of death?       |
| necorus,            | signed I  | d by           | Tak II. Othor organization                                      | The contributing to day         | uiii but not rusu                              | nang in the ui         | loonlying badde give   |                          |   |                                | ☐ Probably 4 ☐Unknown            |
| 5                   | w requir<br>been si<br>should   | lete           |   |                                 | _  |                        |  |                          | 24a. Was  | an 24h Wei                     | re autopsy findings available    |
| ב<br>ב              | he lav<br>e has   | ompleted       |   |                                 |  |                        |  |                          | auto  | psy prio<br>ormęd? dea         | r to completion of cause of th?  |
| VII                 |   | e C            | 25. Was case referred to medical                                |                                 |  |                        |  | 26. Place                | 1 ☐ Yes   |                                | Yes 2 No                         |
|                     | Physici<br>this cer<br>al direc   | To B           | examiner?   | Hospital: 1 ☐ In                | patient 2 🗆 I                                  | ER/Outpatien           | t 3 DOA Othe   | 1-11-                    | rsing Home 5 Mes                                  |                                | (Specify)                        |
| 5                   | ding Ph<br>n.<br>After th<br>funeral  |                | 27. Manny of Death  | 28a. Date o                     | f Injury<br>n, Day Year)                       | 28b. Time of<br>Injury | 28c. Injury<br>Work  |                          |   | how injury occurred            |                                  |
| 2                   | Attending Physician: r death. actor: After this certifics by the funeral director, I  | cati           | 2 Accident investig   | gation not be                   |  |                        |  | /es 2 🗆                  |   |                                |                                  |
| DIVISION            | or At<br>after d<br>Diract<br>in by   | Certification: | 4 Homicide determ   | ined 28e. Place                 | of Injury - At ho<br>ig, etc. <i>(Specif</i> y | me, farm, str          | eet, factory, office   |                          |   | (Street and Number own, State) | or Rural Route Number,           |
| _                   | spital<br>ours a<br>naral l   |                | 29a. Certifier 1 Certifyin                                      | Q Physician: To the             | best of my know                                | wledge death           | occurred at the tim  | e date an                | d place, and due to the                           | cause(s) and manne             | ar as stated                     |
|                     | To the Hospital or Attending I within 24 hours after death. To tha Funaral Diractor: Atter completely filled in by the funer  | edical         | (Check only 2 Medical one)                                      | Examiner: On the ba<br>and mann | sis of examinat                                | ion and/or in          | estigation, in my op   | inion, dea               | th occurred at the time,                          | date and place, and            | due to the cause(s)              |
|                     | To th<br>withir<br>To th<br>comp  | Me             | 29b. Signature and title of certifie                            | 1                               |  | 11. 5                  | 29c License  | number                   | 7/  | 29d. Date signed (A            | Month, Day, Year)                |
|                     | /   |                | Brum  | 1 Cen                           | nev  | レーリー                   | 11/  | 71                       | //  | De Com                         | 2005                             |
|                     | 15  |                | 30. Name and address of person                                  | who completed cause             | of death (Item                                 | 23а) (Туре,            | Print) (1)   | or wy                    | and tel   | ward                           | •                                |
|                     |   | •              | 31. Date filed (Month, Day, Year)                               | 0 c v 1 1/2 32 AR               | egistrar's Signat                              | W C J                  | 1/6/100  |                          | Stev  | - enug                         |                                  |
|                     | Sta<br>Registr  |                |   | 2005                            | Andre a  | e de                   | rate o   |                          |   |                                |                                  |
|                     |   |                |   | - Edw                           | with the state of the                          | 1938                   | The state of the s |                          |   |                                |                                  |

05-08635 LUSKEY, MARIE A For WHM

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Item#2a,27,pen#1,851,1/5/to III
State of Maryland / Department of Health and Mental Hygiene 15 1771

| <b>Physician</b> |
|------------------|
| /Medical         |
| Examiner         |
|                  |

**Funeral** Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked othar than "natural", or Items 23e or 28e-1 show any injury or other traumatic avant, the Madical Examinar must be notified at once.

Baltimore, Maryland 21215-0036

Pnysician /Medical Examiner

To the Hospitel or Attending Physician: The law requires that the death certificate be executed the attending physicien and the for use as the burial-transit Division of Vital Records, P.O. Box 68760, signed by the been si within 24 hours after death.

To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2:

| 1 - State<br>Registrar  | C  | Certificate of Death Reg. No. |   |                                      |                        |  |                         | 1104                 |   |
|---|--|-------------------------------|---|--------------------------------------|------------------------|--|-------------------------|----------------------|---|
| 1. Decedent's Name (First, Middle, Last)  | )  |                               |   |                                      |                        | 2. Date of Death                               | Day                     | Yeer                 | 3. Time of Death                                  |
|   | Marie Ant  | coinett                       | ette Luskey DECEMBER 21,  |                                      |                        |  |                         |                      | 11:40 AM  |
| 4a. Facility Name (If not institution, give   | street and number)   |                               |   |                                      |                        |  |                         | y of Death           |   |
| 14005 BRAMBLE LA  | # 102  |                               |   | AUREL                                |                        |  | PRIN                    | CE GEO               | ORGES CO  |
| 5. Social Security Number 6. Sex  | JW 51XJE   | yrs. last birtho              | Months  | Days Hour                            | der 24 Hrs.<br>'s Min. | 8. Date of Birth (Month, Day,                  | Year)                   | Coun                 |   |
| 214-32-8178 Usuel Residence of Decedent   | 70   | ) 11.                         | S.  |                                      |                        | July 4,  | 1935                    | Vir                  | ginia   |
| 10a. State 10b. County  | 10   | c. City, Town o               | or Location   |                                      |                        | 1  | 0d. Inside City Limits  |                      |   |
| MD Prince G   | oorgo  | Laurel                        |   |                                      |                        |  |                         |                      | 1 ☐ Yes 2X No                                     |
| 10e. Street and Number  | eorge  | Laurer                        | 10f. Zip  | Code                                 |                        | 10   | g. Citizen of           | What Coun            | try?  |
| 14005 Bramble Lan   | 0 #102   |                               |   | 708                                  |                        |  | U.S.A                   |                      | -,-   |
|   | 12. Was Decedent Ever  | r in U.S.                     | 13. Was Dece  | dent of Hispanic                     | Origin? (Spe           | ecify Yes or No-                               |                         | ce - Americ          | an Indian.  |
| 1 Never Married 2 Married   | Armed Forces?<br>1 ☐ Yes 2 💢 No  |                               |   | cify Cuban, Mexi                     |                        | Rican, etc.)                                   |                         | ck, White,           |   |
| 3 ☐ Widowed 4 ☑ Divorced  | If Yes, Give<br>Year or Dates:   |                               | 1 🗆 Yes   | 2⊠ No Spec                           | eity:                  |  | Speci                   | <sup>∱y:</sup> Whit  | .e  |
| 15. Decedent's Edu<br>(Specify only highest grade   | cation   | 16a. D                        | ecedent's Usua  | al Occupation<br>ork done during n   | and of work            | ing 1  | 6b. Kind of E           |                      |   |
| Elementary/Secondary (0-12)   | College (1-4or 5+)   |                               | ife. DO NOT us  | se retired)                          | TOST OF WORK           | ing .  |                         |                      |   |
| 12  |  | Adm                           | inistra   | tive As                              | sistar                 | nt N   | Mortga                  | ge Cor               | mpany   |
| 17. Father's Name (First, Middle, Last)   |  |                               |   | 18. Mo                               | other's Name           | e (First, Middle, M                            | aiden Suma              | me)                  |   |
| Anthony DeFalco   |  |                               |   | Joa                                  | an                     |  |                         | ur                   | ıknown  |
| 19a. Informant's Name/Relationship (Ty  | pe, Print)   | 19b. N                        | Mailing Address   | (Street and Nur                      | mber or Rura           | al Route Number,                               | City or Town            | , State, Zip         | Code)   |
|   | /daughter  | T                             |   |                                      |                        |  |                         |                      | nia 25401   |
| 20a. Method of Disposition 1 ☐ Burial 2 ☒ Cremation 3 ☐ R   |  | 20b. Place of D<br>cemetery,  | isposition (Nar<br>crematory or o   | me of<br>other place)                |                        | Date 2   | Oc. Location            | - City or To         | wn, State   |
| 4 ☐ Donation 5 ☐ Other (Specify)  |  | W. Arun                       | del Cre   | ematory                              | Dec                    | 23, 05   | Odento                  | n, Ma                | ryland  |
| 21. Signatura Funeral Service License   | 1  | 00160                         | Donald  | d Address of Falson Fun              | eral E                 | Home, P.A                                      | A.                      | a 2070               | 7 4200  |
| 23a. Part1. Enter the disease, or compli  |  | 0160                          |   |                                      |                        | aurel, Ma                                      |                         | a 2070               | Approximate                                       |
| resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last | Due to (or as a co   | onsequence of)                | :   |                                      |                        |  |                         |                      |   |
| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 XNo 9 □ Unknown  | 23c. If yes, outcome of p<br>1 Live birth 2 L<br>4 Pregnant at time<br>9 Unknown | Fetal death                   | 3 □Ectopic pr<br>5 □ Other (sp  |                                      |                        |  |                         | ate of delive        | ry<br>Day Year                                    |
| Part II. Other significant conditions con   | ntributing to death but no   | ot resulting in th            | ne underlying c   | ause given in Pa                     | urt I.                 |  | acco use con            | itribute to th       | e cause of death?<br>ably 4 Unknown               |
|   |  |                               |   |                                      |                        | 24a. Was an<br>autopsy<br>perform<br>1 X Yes 2 |                         | prior to con         | osy findings available inpletion of cause of 2 No |
| 25. Was case referred to medical examiner?  | -  |                               |   | 26. PI                               | ace of Death           | Check only one                                 |                         | -                    |   |
| XXYes 2□No  | Hospital: 1 ☐ Inpatient  | 2 ER/Outp                     | atient 3 DC   | OA Other: 4                          | Nursing Ho             | me 5□Resider                                   | ice 6XX0tl              | her <i>(Specif</i> y | SCENE   |
| 27. Manner of Death 1   | 28a. Date of Injury<br>(Month, Day Ye  | 28b. Tin<br>lnju              | ne of 2<br>ury<br>M   | 28c. Injury at<br>Work?<br>1 ☐ Yes 2 |                        | 28d. Describe hov                              | v injury occu           | rred                 |   |
| 3 Suicide 6 Could not be 4 Homicide determined  | 28e. Place of Injury -<br>building, etc. (S                                      | At home, farm<br>Specify)     | , street, factory   | y, office                            |                        | 28f. Location (Stre<br>City or Town,           | et and Num<br>State)    | ber or Rura          | Route Number,                                     |
| 29a. Certifier 1 Certifying Phys  | sician: To the best of m   | y knowledge, d                | nowledge, death occurred at the time, date and place, and due to the cau<br>nation and/or investigation, in my opinion, death occurred at the time, dat |                                      |                        |  |                         | anner as st          | ated.<br>the cause(s)                             |
| (Check only 2 Medical Examination)  | and manner stated.   | amination and/                |   |                                      |                        |  |                         |                      | . ,   |
| (Check only 2 X Medical Examin  | and manner stated.   | amination and/                |   | c. License numb                      |                        | 1  | d. Date signe           |                      | Day, Year)  |
| (Check only 2 X Medical Examile one)  | and manner stated.   | L . ~                         |   | O C M E                              |                        | 1  | d. Date signe<br>ECEMBE |                      | Day, Year)  |
| (Check only 2 Medical Examination)  29b. Signature and title of certifier   | and manner stated.   | de .s                         | 290   |                                      |                        | 1  | -                       |                      | Day, Year)  |
| (Check only 2 X Medical Examile one)  | and manner stated.   | oli vo                        | 290<br>(09. Print)  | ОСМЕ                                 | <u>C</u>               | 1  | ECEMBE                  | R 22,                | 2005  |

State

Registrar

DEC 2 7 2005

DHMH 17 Rev 1/2001

32. Heyisuan day

|       |                            |   |                     | 1 - For<br>Registrar  | State of Maryl  |                               | artment of h  |   |   | ene<br>2005                                | 41705  |
|-------|----------------------------|---|---------------------|---|---|-------------------------------|---|---|---|--|--|
|       |                            | Physici   | ian                 | Decedent's Name (First, Middle, Last)   |   |                               |   |   | 2. Date of Death<br>Month                     | Day Year                                   | 3. Time of Death                                   |
| 4     |                            | /Medi   | cal                 | 4a. Facility Name (If not institution, give   | Benjamin  | Wayne                         |   | and another of Donath                                       | DEC   | 25, 2005                                   |  |
|       |                            | Examir  | ner                 | Stella Maris  |   |                               |   | or Location of Death  |   | 4c. County of Deat Balti                   |  |
|       |                            | Funeral<br>Director   |                     | 5. Social Security Number 6. Se   | 7. Age (In  | yrs. last birthday) 50 Yrs.   |   | If Under 24 Hrs.<br>Hours Min.                              | 8. Date of Birth<br>(Month, Day, )<br>OCT 21, | O Diet                                     | hplace (State or Foreign untry) rvland             |
|       |                            | pug *   |                     | Usual Residence of Decedent  10a. State 10b. County   | 100   | c. City, Town or Lo           | ocation   |   |   |  |  |
|       |                            | Marylan<br>a-f show   | tor                 | MD Balti  |   | s. Only, Yourn of Ex          |   | ville   |   |  | 10d. Inside City Limits 1 ☐ Yes 2 🔀 No             |
|       |                            | or 28s  | Olrec               | 10e. Street and Number  |   |                               | 10f. Zip Code   |   | 100   | g. Citizen of What Co                      | untry?   |
|       |                            | ath w   | ral                 | 2803 Taylor A   |   |                               |   | 21234   |   | USA  |  |
| É     | 5-0036                     | filed within 72 hours after death with the Maryland<br>Hygiene.<br>uther than "naturel", or Itema 23a or 28a-f show<br>thit, the Medical Exam. ar trust be tradified at   | by Funeral Director | 11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced   | 12. Was Decedent Ever i<br>Armed Forces?<br>1 ☐ Yes 2 ▼No<br>If Yes, Give<br>Year or Dates: |                               | Was Decedent of H<br>If Yes, specify Cub<br>1□Yes 2X No | Hispanic Origin? (Spe<br>pan, Mexican, Puerto I<br>Specify: | ecify Yes or No-<br>Rican, etc.)              | 14. Race - Ame<br>Black, White<br>Specify: |  |
| N     | 5-0                        | 72 ho<br>'natur   | Completed           | 15. Decedent's Edu<br>(Specify only highest grad  | cation<br>e completed)  | 16a. Dece                     | dent's Usual Occup                                      | pation<br>during most of workii<br>dd)                      | ng 16   | 6b. Kind of Business/                      |  |
| N     | 2121                       | d within<br>giene.<br>rr than   | dmo                 | Elementary/Secondary (0-12)   | College (1-4or 5+)  |                               |   | id)<br>Installei  |   | Construc                                   | tion   |
| ic    |                            | il Hygie<br>other   | Be Co               | 17. Father's Name (First, Middle, Last)   |   | 111503                        | Lation ]  | 18. Mother's Name   |   |  | LIOH   |
|       | Maryland                   | ges 1 and 2 should be filed<br>t of Health and Mental Hyg<br>If item 27 Is marked othe<br>or other traumatic event,   | To B                | Emory Ma  | yo Lamb   |                               |   | Blanc   | che   | Shi  | pley   |
| 5     | Man                        | 2 sho   |                     | 19a. Informant's Name/Relationship (Ty  |   |                               |   |   |   | City or Town, State, Z                     |  |
| A     |                            | f Health<br>frem 27<br>other tra  |                     | Deborah J. Lamb   |   | Db. Place of Dispo            | sition (Name of   | r Avenue  |   | ille, MD                                   |  |
| -25   | E O                        | Pages<br>nent of<br>int: If it  |                     | 1 Burial 2 XCremation 3 F   | Removal from State  | cemetery, crei                | matory`or other pla<br>oma horsz                        | Tnc   12/2  | 6/05  | Poltimo                                    | MD MD  |
| 12    | Baltimore,                 | permit. Page<br>Department of<br>Important: If<br>any injury or<br>once.  |                     | 21. Signature of Funeral Service Licens  23a Part 1 Enter the disease or compile  | George Ma   | icNahh 22                     | Name and Addre  | iss of Facility   | ety of  | Maryland                                   | , Inc.   |
| DK/ME | 68760,                     | Physician /Medical Examiner buriay: Italian and street buriay: Italian and | edical Examiner     | 23a. Part1. Enter the disease, or complishock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | Due to (or as a condition)  Due to (or as a condition)  Due to (or as a condition)          | AGE LV                        | er dis  |   |   | ,  | Approximate<br>Interval Between<br>Onset and Death |
| amb   | О. Вох                     | requires that the death certifi<br>een signed by the atlending<br>hould be detached for use as  | by Physician/Me     | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown   | 3c. If yes, outcome of pre<br>1 □ Live birth 2 □ F<br>4 □ Pregnant at time<br>9 □ Unknown   | Fetal death 3                 | Ectopic pregnancy Other (specify)                       | у   |   | 23d. Date of deli<br>Month                 | very<br>Day Year                                   |
| re L  | ds, P                      | uires that the de<br>signed by the<br>Id be detached  | d by P              | Part II. Other significant conditions con   | ntributing to death but not   | resulting in the u            | nderlying cause giv                                     | ven in Part I.  | 23e. Did toba                                 | cco use contribute to                      | 9.0  |
| Wayne | , 00                       | law requir<br>as been s<br>2 should   | plete               |   |   |                               | 7   |   | 24a. Was an                                   | 24b. Were au                               | topsy findings available ompletion of cause of     |
| 3     | tal Re                     | The<br>rate hy<br>page  | e Completed         | 25. Was case referred to medical  |   |                               |   |   | -   | da death?                                  | ompletion of cause of                              |
| E     |                            | Physician:<br>this certific<br>ral director,  | To Be               | examiner?   | lospital:   | 2 ER/Outpatien                | it 3□ DOA Oth   | 26. Place of Death  | Check only one                                | ce 5 ther (Spec                            | Hassis   |
| jamin | Division of Vital Records, | ding<br>After<br>fune   | Certification: 1    | 27. Manner of Death  Natural 5 Pending investigation  | 28a. Date of Injury<br>(Month, Day Year   | 28b. Time of                  | 28c. Injur<br>Wor                                       |   | 28d. Describe how                             |  | "Y) 1705 p 1 Cz                                    |
| Banj  | Divis                      | tal or Att<br>rs after d<br>al Direct<br>ed in by t   | Certific            | 3 Suicide 6 Could not be<br>4 Homicide determined   | 28e. Place of Injury - A building, etc. (Sp.  | At home, farm, str<br>pecify) | eet, factory, office                                    | 2   | 8f. Location (Stree<br>City or Town, S        | et and Number or Rui<br>State)             | ral Route Number,                                  |
|       |                            | To the Hospital or Attend<br>within 24 hours after death<br>To the Funeral Director:<br>completely filled in by the   | Medical             | 29a. Certifier 1.7 Certifying Physical Check only 2 Medical Extenditions one)   | sician: To the best of my<br>ner: On the basis of exam<br>and manner stated.                | knowledge, death              | n occurred at the tirvestigation, in my o               | me, date and place, a<br>opinion, death occurre             | and due to the caused at the time, date       | se(s) and manner as<br>and place, and due  | stated.<br>to the cause(s)                         |
|       |                            | With<br>Tot   | 2                   | 29b. Signature and title of certifier   | )   |                               | 29c. Licens   | se number   | 29d   | . Date signed (Month                       | , Day, Year)                                       |
| 4     |                            | 6   |                     | ,   | 4   |                               | D   | 13725   |   | 12-26-                                     | 05   |
|       | 5                          | 1   |                     | 30. Name and address of person who co   | mpleted cause of death (  | (Item 23a) (Type,             | Print)  | Dutner  | · Vai   | EN DE                                      | Titerana   |
|       |                            | Sta<br>Registr  |                     | 31. Date filed (Month, Day, Year)  DFC 2. 7 20  | 32. Registrar's Si  | ignature                      | auth 1  | y = 117 E   | 7 7112  | T Ka                                       | MD 21093   |

|                                |   | •              | For<br>State<br>Registrar  | State of M   | larylan                             |                        |                      |                       | lealth a                    | and M       | _                                       | giene<br>Reg. No.        | 005                     | 10.00    | +17                                   | 06                    |
|--------------------------------|---|----------------|--|--|-------------------------------------|------------------------|----------------------|-----------------------|-----------------------------|-------------|---|--------------------------|-------------------------|----------|---------------------------------------|-----------------------|
|                                | Physici   | an             | Decedent's Name (First, Middle, La   | ,  |                                     |                        |                      |                       |                             |             | 2. Date of De<br>Month                  | ath<br>Day               | Ye                      | ar       | 3. Time o                             | f Death               |
|                                | /Medic  | _              |  | Doris  |                                     | ed Mar                 |                      |                       |                             |             | Decemb                                  | er 2                     | 2, 20                   | 05       | 4:05                                  | 5 P M                 |
|                                | Examin  | er             | 4a. Facility Name (If not institution, gi  |  | ,                                   |                        |                      |                       | Location o                  | of Death    |   |                          | County of I             |          |                                       |                       |
|                                | 3.5   | 20             | Gladys Spellman 5. Social Security Number 6.   |  |                                     | last birthday)         |                      | ttsvi<br>er 1 Year    | lle<br>  fUnder:            | 24 Hrs.     | 8 Date of Rin                           |                          | rince                   |          | orge<br>ace (State                    | or Foreign            |
|                                | Funeral Director  | j l            |  | 1□M 2⊠F  | 77                                  | Yrs.                   | Month                |                       | Hours                       | Min.        | 8. Date of Bird<br>(Month, Da<br>Sept 2 | y, Year)                 |                         | Count    | ry)                                   | or Foreign            |
| 12.7                           | D   |                | Usual Residence of Decedent  |  |                                     |                        |                      |                       |                             |             |   |                          |                         |          |                                       |                       |
|                                | arylar  | _              | 10a. State 10b. County   |  | 10c. Cit                            | ty, Town or Lo         | cation               |                       |                             |             |   |                          |                         | 10       | d. Inside C                           | *                     |
|                                | Ne M  | Director       | MD Prince  | George   | La                                  | urel                   | 1                    |                       |                             |             | -                                       |                          |                         |          |                                       | 2 No                  |
|                                | with t  |                | 10e. Street and Number   |  |                                     |                        |                      | ip Code               |                             |             |   |                          | zen of Wha              | t Count  | ry?                                   |                       |
|                                | heath   | erai           | 1002 Turney Aver   | 12. Was Deceden  | t Ever in U                         | S 13 V                 |                      | 0707                  | ispanic Orio                | nin? (Spe   | cify Yes or No                          | U.S                      | . A .<br>14. Race       | America  | n Indian                              |                       |
| 326                            | 2 should be filed within 72 hours after death with the Maryland and Member Hygiene. and Member Hygiene. Is marked ther than "natural", or items 23a or 28a-f show eumatic event, the Mudical Examinational the notilised at | by Funerai     | 1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced   | Armed Forces 1  Yes 2  If Yes, Give Year or Dates                      | ?<br>[No                            | 1                      | f Yes, sp            | ecify Cuba<br>2 X No  | n, Mexican                  | , Puerto I  | Rican, etc.)                            |                          | Black, \                | White, e | itc.                                  |                       |
| Š                              | 2 hou   | ted            | 15. Decedent's E   | ducation   |                                     | 16a. Deced             | ient's Us            | ual Occupa            | ation                       |             |   | 16b. Ki                  | nd of Busin             | ess/Ind  | ustry                                 |                       |
| 2                              | thin 7  | ad L           | (Specify only highest gi<br>Elementary/Secondary (0-12)  | College (1-4or   | 5+)                                 | life. L                | DO NOT               | use retired           | during most<br>()           | t of workii | ng                                      |                          |                         |          |                                       |                       |
| 7                              | filed wi<br>Hygien<br>other th  | Completed      | 12   |  |                                     | Cler                   | k                    |                       |                             |             |   |                          | lepho                   | ne C     | Compar                                | ny                    |
|                                | tal H<br>d oth  | Be             | 17. Father's Name (First, Middle, Las  |  |                                     |                        |                      |                       |                             |             | (First, Middle,                         | Maiden                   | Sumame)                 |          |                                       |                       |
| 2                              | should be<br>and Mental<br>s marked o<br>umatic eve   | ဥ              | Charles Franklin   |  |                                     | 401 44 11              |                      |                       |                             |             | nacio                                   |                          |                         |          |                                       |                       |
| <u>a</u>                       | d 2 st<br>th and<br>th and<br>treur<br>treur  |                |  | spouse   |                                     |                        |                      |                       |                             |             | / Route Number                          |                          |                         | te, Zip  | Code)                                 |                       |
| ō,                             | Heal<br>Heal<br>tem 2   |                | 20a. Method of Disposition   | spouse   | 20b. F                              | Place of Dispo         | sition (N            | ame of                |                             |             | aryland                                 |                          | / 25<br>cation - Cit    | y or Tov | vn, State                             |                       |
| ē                              | ages<br>ant of<br>at: If it   | - 1            | 1 Burial 2 Cremation 3<br>4 Donation 5 Other (Spec   |  | 9                                   | cemetery, cren         | -                    |                       |                             | \~~ ?       | 0 05                                    |                          |                         |          |                                       |                       |
| Baitimore, Maryland 21215-0036 | permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any Injury or other treumatic evonce.  | li             | 21. Signature of Funeral S. Li   | 4  | IIV                                 | y Hill<br>22           | . Name               | and Addres            | s of Facilit                | v           | 8, 05                                   |                          | cel, N                  | dary     | Tand                                  |                       |
| ñ                              | Ded in the  |                | & Shit Hand  | h  | моо                                 |                        |                      |                       |                             |             | ome, P.<br>urel, N                      |                          | land '                  | 2በ7በ     | 7-438                                 | 2 Q                   |
| 4 <sup>(2)</sup>               | Physician   |                | 23a. Part 1. Enter the disease, or cor<br>shock, of heart failure. List only<br>Immediate Cause (Final<br>disease or condition<br>resulting in death)      | nplications that cause<br>y one cause on each<br>aVentric              | line.                               | h. Do not ent          | er the m             | ode of dyin           | g, such as                  | cardiac o   | r respiratory a                         | rrest,                   |                         |          | Approxima<br>Interval Be<br>Onset and | te<br>tween           |
| 8760,                          | Medical  Examiner  physician and the burial-fransit   | dical Examiner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. COPONAL  Due to (or a  c. Due to (or a                              | ry Ar                               | tery D:                | isea                 | se                    |                             |             |   |                          |                         |          |                                       |                       |
| P.O. Box 6                     | requires that the death certific<br>seen signed by the attending p<br>hould be detached for use as:   | Physician/Me   | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown  | 23c. If yes, outcom<br>1 ☐ Live birth<br>4 ☐ Pregnant a<br>9 ☐ Unknown | 2 🗆 Feta                            | ıl déath 3 ☐           | Ectopic<br>Other (   | pregnancy<br>specify) |                             |             |   | 2                        | 23d. Date o<br>Month    |          | -                                     | Year                  |
|                                | w requires that the de<br>been signed by the a<br>should be detached f  | <u>م</u>       | Part II. Other significant conditions Pacemaker insert   |  |                                     |                        |                      |                       | en in Part I.               |             |   | obacco u<br>Yes 2[       | se contribu             |          | ecause of                             |                       |
| Division of Vital Records,     | Physiclan: The law re<br>this certificate has be<br>ral director, page 2 sho  | Completed      | Respiratory fail   | ure  |                                     |                        |                      |                       |                             |             | 24a. Was<br>autor<br>perio              |                          | prio                    | r to com | sy findings                           | available<br>cause of |
| ita                            | artifica<br>ctor,   | Be             | 25. Was case referred to medical examiner?   |  |                                     |                        |                      |                       | 26. Place                   | of Death    | Check only                              |                          |                         |          |                                       |                       |
| ×                              | hysic<br>his ce<br>il dire  | ဥ              | 1 ☐ Yes 2 🔀 No   |  |                                     | ER/Outpatien           | t 3□ [               |                       | 4 (X) 14u                   | rsing Hor   | ne 5⊟Resi                               | dence 6                  | S □Other (              | Specify  | )                                     |                       |
| Č                              | ing P   | ë.             | 27. Manner of Death 1 XNatural 5 ☐ Pending   | 28a. Date of Inj<br>(Month, D  | ury<br>ay Year)                     | 28b. Time of<br>Injury |                      | 28c. Injun<br>Worl    |                             |             | 28d. Describe                           | how injur                | y occurred              |          |                                       |                       |
| 200                            | Attending Physician: r death. sctor: Atter this certific by the funeral director,   | cat            | 2 Accident investigation 3 Suicide 6 Could not   | 20   |                                     |                        | М                    |                       | Yes 2 🗆 !                   |             |   |                          |                         |          |                                       |                       |
|                                | after after Direct  | Certification: | 4 Homicide determined  | 286. Place of Ir   | njury - At h<br>etc. <i>(Specil</i> | ome, farm, str<br>fy)  | eet, facto           | ory, office           |                             | 2           | 28f. Location (:<br>City or Tox         | Street and<br>wn, State, | d Number (<br>)         | r Rural  | Route Nur                             | nber.                 |
|                                | To the Hospital or Attending Ph<br>within 24 hours after death.<br>To the Funeral Director: After th<br>completely filled in by the funeral   | edicai C       | 29a. Certifier 1 Certifying P (Check only one) 2 Medical Exa   | hysician: T. the basis<br>miner: On the basis<br>and manner s          | of examina                          | wiedge death           | ocuma<br>vestigation | on, in my o           | te, date an<br>pinion, deal | diplace a   | and dua to the                          | causa(s)<br>date and     | and manne<br>place, and | due to   | ited.<br>the cause(                   | s)                    |
|                                | To th<br>within<br>To th<br>compl   | ₩<br>W         | 29b. Signature and tyle of certifier   | 1 10   |                                     |                        | 2                    | 9c. License           | e number                    |             |   | 29d. Dat                 | e signed (A             | fonth, E | Day, Year)                            |                       |
| •                              | 1   |                | Ilela 1.   | MOT)   | 10                                  |                        |                      | D002                  | 6024                        |             |   | Dece                     | mber                    | 23,      | 2005                                  |                       |
|                                | 15  |                | 30. Name and address of person who   | completed cause of   | death (Iter                         | n 23a) (Type,          | Print)               |                       | -                           |             |   |                          |                         |          |                                       |                       |
|                                | 1,  |                | Lester Miles, M.   | 250  |                                     |                        |                      | Suite                 | F, L                        | ando        | ver, Ma                                 | aryla                    | nd 20                   | 785      |                                       |                       |
|                                | Sta<br>Registi  | 900            | 31. Date filed (Morth, Day Year) 2   | UUD Beeis  | rars Sign                           | uure eruu              |                      |                       |                             |             |   |                          |                         |          |                                       |                       |

|                 |  |                | 1 - For<br>State<br>Registrar  | State of Mai   |                          | partment of F<br>ertificate of                     |  |   | ene<br>0 0 5                                      | 41707  |
|-----------------|--|----------------|--|--|--------------------------|--|--|---|---|--|
|                 | Physicia   | an             | 1. Decedent's Name (First, Middle, La  | st)  |                          |  |  | 2. Date of Death<br>Month                                   |   | 3. Time of Death                                   |
|                 | /Medic   | al             | THOMAS   | MAR  | TIN                      | # C' T   |  | DECEMBER  | R 24, 2005  | 3:00 P. M.   |
|                 | Examin   | er             | 4a. Facility Name (If not institution, given FOREST HILL HEA                       | ,  |                          | FOREST   | HTT.T.   |   | 4c. County of Death HARFORD                       |  |
|                 | Funeral  |                |  |  | (In yrs. last birthda    |  | If Under 24 Hrs.<br>Hours Min.                 | 8. Date of Birth<br>(Month, Day,                            |   | place (State or Foreign                            |
|                 | Director   |                | Usual Residence of Decedent  | NOM 20F  | Yrs.                     |  |  | 062-14 10   | 134 MAR   | VLAND  |
|                 | nyland<br>how  |                | 10a. State 10b. County   |  | 10c. City, Town or       | Location   |  |   |   | 10d. Inside City Limits                            |
|                 | 8a-fs  | Director       | CARAJAN HARFY  |  | FORIST                   | This ?   |  |   |   | 1 ☐ Yes 2 No                                       |
|                 | with the   | Dire           | 10e. Street and Number   | 000  |                          | 10f. Zip Code                                      |  | 10  | g. Citizen of What Cou                            | intry?   |
|                 | death  | nera           | 808 YVITI  | 12. Was Decedent Ev  | ver in U.S.              | 3. Was Decedent of F                               | Hispanic Origin? (Spean, Mexican, Puerto       | cify Yes or No-   | 14. Race - Amer                                   |  |
| 36              | s after<br>, or Ite  | by Funeral     | 1 Never Married 25 Married   | Armed Forces?<br>1 1 Yes 2 □ No<br>If Yes, Give                          |                          | 1 ☐ Yes 2 🗖 No                                     | Specify:                                       | Hican, etc.)  | Black, White                                      | , etc.   |
| 21215-0036      | within 72 hours after death with the Maryland<br>ene.<br>than "natural", or Items 23s or 28s-f show<br>he Modical Examiner must be notified at   | ed b           | 3 ☐ Widowed 4 ☐ Divorced  15. Decedent's E   | Year or Dates:   | H72310.                  | cedent's Usual Occup                               | pation   |   | 6b. Kind of Business/Ir                           | 3/12   |
| 215             | thin 72<br>e.<br>en "na  | Completed      | (Specify only highest gr<br>Elementary/Secondary (0-12)                            | ade completed)  College (1-4or 5+  | (Gi                      | ve kind of work done . DO NOT use retire           | during most of worki                           | ng  | $\cap$  |  |
|                 | filed withi<br>Hygiene.<br>other than<br>ant, II'e M   |                | 12 Y RS-<br>17. Father's Name (First, Middle, Las.                                 | 7X62-  | 6                        | HIMIS  | 18. Mother's Name                              | (First Middle M   | KESZARC.  | 4  |
| Maryland        | should be f<br>nd Mental h<br>marked of  | To Be          | FRANCIS A.   | PARTIE   |                          |  | 18. Mother's Name                              | (First, Middle, M   | ) Al live   | rV.  |
| ary             | 2 should be and Mental la marked o   | -              | 19a. Informant's Name/Relationship   |  | 19b. Ma                  | iling Address (Street                              | and Number or Rura                             | I Route Number,   | City or Town, State, Zi                           | p Code)  |
|                 | - 5 € G  |                | JOAN MARTIC  | <b>\</b>   | 308                      | YVZTE  | Drive Fo                                       | HIZE  | IL MARALA   | no 21050   |
| nor             | Pages hent of hent or other hent of hent or other he |                | 20a. Method of Disposition  1 Burial 2 Cremation 3                                 |  | cometery, c              | position (Name of<br>rematory or other pla         | CO) LOCK                                       | gd' -   | Oc. Location - City or T                          | own, State   |
| Baltimore,      | 그 문원들  |                | 1. Fig. 11 = of F meral 5 rvice Lich   |  | - Cortain                | 22. Name and Addre                                 |  | $\frac{\partial}{\partial z} = \frac{\partial}{\partial z}$ | AR, PA  | 1 letareun   |
| ä               | permi<br>Depa<br>Impo<br>any it  |                | NO ACOS  |  | 2                        | 3 NEWPOR   | LOGINS   | FORIT   | HILL MAR  | MANO DIAL  |
|                 |  |                | 23a. Part1. Enter the disease, or conshock, or heart failure. List only            | polications that caused to<br>one cause on each line                     | he death. Do not e       | enter the mode of dyin                             | ng, such as cardiac o                          | r respiratory arre  | st,   | Approximate<br>Interval Between<br>Onset and Death |
|                 | Pnysician /<br>/Medical  |                | Immediate Cause (Final disease or condition resulting in death)                    | a. Due to for as a   | consequence of):         | - can  | -  |   |   |  |
|                 | Examiner   |                | Constraints for the distance   | b.   | consequence or,          |  |  |   |   |  |
| H               | sit ad   | iner           | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying |  | consequence of):         |  |  |   |   |  |
|                 | execute<br>and<br>al-tran  | Examiner       | Cause (Disease or injury that initiated events resulting in death) Last            | c<br>Due to (or as a   | consequence of):         |  |  |   |   |  |
| 68760,          | ificate be executed<br>g physician and<br>as the burial-transit  | edicai E       | (  | d  |                          |  |  |   |   |  |
| _               |  |                | IF FEMALE:   |  |                          |  | · · · · · · · · · · · · · · · · · · ·          |   |   |  |
| Вох             | death certifii<br>e attending p<br>id for use as   | Physician/M    | 23b. Was decedent pregnant in the past 12 months?                                  | 23c. If yes, outcome of 1 Live birth 2 4 Pregnant at ti                  | Fetal death              | B Ectopic pregnanc                                 | у  |   | 23d. Date of deliv<br>Month                       | rery<br>Day Year                                   |
| P.O.            | w requires that the de<br>been signed by the s<br>should be detached   | hysi           | 1 Yes 2 No<br>9 Unknown  | 9 Unknown  |                          |  |  |   |   |  |
| Ś               | The law requires that the ste has been signed by the bage 2 should be detache  | by             | Part II. Other significant conditions  | contributing to death but  | not resulting in the     | underlying cause giv                               | ven in Part I.                                 |   | acco use contribute to                            | \  |
| Sorc            | r requi  | eted           |  |  |                          |  |  |   | s 2 No 3 Pro                                      |  |
| Rec             | he ta<br>e has   | Completed      |  |  | * ***                    |  |  | 24a. Was an<br>autopsy<br>perform                           | prior to co<br>led? death?                        | opsy findings available<br>empletion of cause of   |
| of Vital Record | ilcian: Th<br>certificate<br>rector, pag   | BeC            | 25. Was case referred to medical examiner?   |  |                          |  | 26. Place of Death                             |   | □No 1 □ Yes                                       | & NO   |
| of <            | Physician:<br>this certific<br>ral director.   | ၉              | 1 ☐ Yes 2 No   |  | t 2 ER/Outpat            |  |  |   | nce 6 Other (Speci                                | ty)  |
| On              | Attending In death.  | tlon           | 27. Manner of Death Natural 5 Pending 2 Accident investigated                      | 28a. Date of Injury<br>(Month, Day                                       | Year) 28b. Time<br>Injun | / Wo   |  | 28d. Describe hov   | w injury occurred                                 |  |
| Division        | tel or Attending Physician: T<br>s after death.<br>al Director: After this certificat<br>ed in by the funeral director, pa   | Certification; | 3 Suicide 6 Could not l  | OB Disease their   | y - At home, farm,       | street, factory, office                            |  | 28f. Location (Str.<br>City or Town,                        | eet and Number or Rur<br>State)                   | al Route Number,                                   |
| ā               | Hospital or<br>24 hours afte<br>Funeral Dir<br>tely filled in  |                |  |  |                          |  |  |   |   |  |
|                 |  | edical         | 29a. Certifier  (Check only one)  1 Certifying P  2 Medicel Exe                    | hysician: To the best of<br>miner: On the basis of e<br>and manner state | examination and/or       | ath occurred at the till<br>investigation, in my o | me, date and place, a<br>opinion, death occurr | and due to the car<br>ed at the time, da                    | use(s) and manner as a<br>te and place, and due t | stated.<br>to the cause(s)                         |
|                 | To the within 2 To the comple  | Me             | 29b. Signature and title of certifier  |  |                          | 29c. Licens  | se number                                      | 29  | d. Date signed (Month,                            | Day, Year)   |
|                 | 1  |                | Davids   | D  |                          |  | 2277   | 2   | ech 2   | 7.2005   |
|                 | 15   |                | DR. PETER LOPREST  |  |                          |  | _ EDCERO                                       | )D 34D 0  | 10/0  |  |
|                 | Sta  |                | 31. Date filed (Month, Day, Year)  | 20 Dominton  | da Ciamatura             |  | - EDGEWUC                                      | ມ <b>,</b> MD 2.  | 1040  |  |
|                 | Registi  | ar             | DEC 2 7  | 2005   | is signature             | gover  |  |   |   |  |

|                             |  |                     | Please  | Type or Print in   |  |  | =  | _   |                                  |
|-----------------------------|--|---------------------|---|--|--|--|--|---|----------------------------------|
|                             |  |                     | For   | State of Marylar   | •  | nt of Health and   | Mental Hygie                                 | 79115                                     | 41708                            |
|                             |  |                     | 1 - Stata<br>Ragistrar  |  | Certifica  | te of Death  | Reg  | . No.                                     | 91700                            |
| ī                           | Physici<br>/Medic  |                     | 1. Decedent's Name (First, Middle, La   | wid A  | laver S  | SR.  | 2. Date of Death<br>Month                    | Day Year                                  | 3. Time of Death                 |
|                             | Examin   |                     | 4a. Facility Name (If not institution, gi   | re street and number)  | 4b. Cit  | y, Town, or Location of Deat                                   | h<br>le                                      | 4c. County of De                          | ath<br>Cod                       |
| ī                           | Funeral  |                     |   | Sex. 7. Age (In yrs.   | . last birthday) If Und<br>Months                    | er 1 Year   If Under 24 Hrs<br>s Days Hours Min.               | (Month, Day, Y                               | (ear) 9. Bi                               | irthplace (State or Foreign      |
| 7                           | Director   |                     | Usual Residence of Decedent  10a. State 10b. County   |  | ity, Town or Location                                |  | 17-2-4                                       | d MK                                      | 10d. Inside City Limits          |
| clareM o                    | ia-f sho   | ctor                | MD Har  | ford   | Jarret   | tsville  |  |   | 1 🗆 Yes 2 🔾 🗓                    |
| ial ylallu K. K. I. J. 2000 | perior. Tages I am a Should be may write it allows are locatin with the way as<br>Department of Health and Mental Hygiene.<br>Important: if item 27 is marked other than "netural", or Items 23e or 28a-1 show<br>any injury or other traumatic event, the Medical Examinar must be notified at<br>Once.   | by Funeral Director | 10e. Street and Number  | 411 Rd   | 10f. Z   | 2108U  | 10g  | . Citizen of What C                       | country?                         |
| 1000                        | IMS 2  | ner                 | 11. Marital Status  | 12. Was Decedent Ever in U<br>Armed Forces?  | J.S. 13. Was Dec                                     | edent of Hispanic Origin? (Secify Cuban, Mexican, Puen         | Specify Yes or No-                           | 14. Race - Am                             |                                  |
| 200                         | II', or its  | by Fu               | 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced  | 1 Yes 2 No If Yes, Give Year or Dates:   |  | 2 No Specify:  | to nicati, etc.)                             | Black, Wh                                 | ine, etc.                        |
| 5 8                         | neture   | eted                | 15. Decedeni's E<br>(Specify only highest gi  | ducation<br>ade completed)   | 16a. Decedent's Us<br>(Give kind of w                | ual Occupation<br>rork done during most of wo<br>use retired)  | rking 16                                     | b. Kind of Busines                        | s/Industry                       |
| Z LZ                        | and Mental Hygiene. is marked other than aumatic event, the Ma   | Completed           | Elementary/Secondary (0-12)   | College (1-4or 5+)   | Account  | Managei  |  | Tofo T.                                   | ech.                             |
| 3                           | al Hy<br>d oth   | Be (                | 17. Father's Name (First, Middle Las  | " 11.  |  | 18. Mother's Na  | me (First, Middle, Ma                        | iden Sumame)                              | 1 11 11                          |
| <b>y</b> 10                 | Ment<br>Arka<br>arka   | ပို                 | Maxwell ca  | rition Inc   | ryer   | Mara   | aret e                                       | lizapet                                   | h Hall                           |
| Mai                         | Ith and Ith an |                     | 19a. Informant's Name/Relationship  | (Type, Print)  | 9b. Mailing Addre                                    | ss (Street and Nu ber or R                                     | I Route Number (                             | City or Town, State,                      | Zip Code) 21030                  |
| U +                         | of Health<br>of Health<br>if itam 27<br>r othar tr   |                     | 20a. Method of Disposition  1 ØBurial 2 □ Cremation 3   | 20b.   | Place of Disposition (N. cemetery, crematory or      | ame of other place)  | Date 20                                      | c. Location City o                        | r Town, State                    |
|                             | Department of Health<br>Department of Health<br>Important: If itam 27<br>any injury or othar tr<br>once.   |                     | *4 □ Donation 5 □ Other (Spec<br>21. Signature of Funeral Service Lice                                      | is) Die  |  | MCM GOODENS  | 12-29-05                                     | TIMON                                     |                                  |
| מ                           | Departr<br>Departr<br>Imports<br>any inju  |                     | XINIKOLLU I   | 1. Suvestan  | Fuinsi   | nd Address of Facility C                                       | FI-DEIAN                                     | 31440                                     | OUT NE                           |
| 51                          | 100  |                     | 23a. Part . Enter the disease, or co-<br>shock, or heart failure. Lift only                                 | o lication, that caused the dra  | th. Do not enter the mo                              | ode of dying, such as cardia                                   | or respiratory arres                         | , O ME TO                                 | Approximate<br>Interval Between  |
|                             | hysician   |                     | Immediate Cause (Final disease or condition   | Myocan   |  | farction   |  |   | Onset and Death                  |
|                             | /Medical<br>Examiner   |                     | resulting in death)   | Due to (or as a conse  | 1  | disease  |  |   | Years                            |
| 7                           | sië g  | iner                | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | Due to (or as a conse  | U U  | M. 111   |  |   | 400.0                            |
| ,,                          | ysician and se burial-transit  | Examiner            | that initiated events<br>resulting in death) Last   | c. Due to (on as a conse   | Dialeter   | - Mellitus   |  |   | jesche                           |
|                             | ohysicia<br>the bur  | cai                 |   | a. Atheroscl   | erosis   |  |  |   | years                            |
| 2 40                        | anding puse as   | n/Me                | IF FEMALE:<br>23b. Was decedent pregnant  | 23c. If yes, outcome of pregn<br>1□Live birth 2 □ Fet                                  |  |  |  | 23d. Date of de                           | elivery                          |
| ָה<br>הַ                    | / the atte   | Physiclan/Medi      | in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown   | 4☐Pregnant at time of 9☐ Unknown   |  |  |  | Month                                     | Day Year                         |
| <u>ה</u>                    | into law requires that the death entimerate the has been signed by the attending phys page 2 should be detached for use as the   | by                  | Part II. Other significant conditions   | contributing to death but not re-  | sulting in the underlying                            | cause given in Part I.   |  | 11  | lo the cause of death?           |
| , כו מטי                    | been s   | eted                |   |  |  |  | 1 ☐ Yes<br>24a. Was an                       |   | autopsy findings available       |
| בי ביינו<br>ביינו           | s certificate has t<br>lirector, page 2 s  | Completed           |   |  |  |  | autopsy<br>performe                          | prior to                                  | completion of cause of           |
| A II d                      | certific   | Be                  | 25. Was case referred to medical examiner?  | Hospital:  |  | Othor  | ath (Check only one)                         |   |                                  |
| 5                           | After this funeral dir   | . To                | 1 ☐ Yes 2 No 27. Magner of Death  | 28a. Date of Injury  | ☐ ER/Outpatient 3☐ 0                                 |  | dome 5 esidence 28d. scribe how              | e 6 ☐Other (Spa                           | ecify)                           |
|                             | ath.<br>or: After  | ation               | 1 Natural 5 ☐ Pending<br>2 ☐ Accident investigate   | (Month, Day Year)  | Injury M   | 28c, Injury at<br>Work?<br>1 ☐ Yes 2 ☐ No                      |  | anjuly obtained                           |                                  |
|                             | after de<br>Diracto  | Certification:      | 3 ☐ Suicide 6 ☐ Could not<br>4 ☐ Homicide determine   |  | nome, farm, street, factorify)                       | ory, office  | 28f. Location (Stree<br>City or Town,        |   | Rural Route Number,              |
|                             | To the hospiter of analysing rigardar. The within 24 hours after death.  To the Funeral Director: After this certificate he completely filled in by the funeral director, page   | edical C            | 29a. Certifier (Check only one)  1X Certifying P 2 Medical Exe  | hysician: To the best of my kn<br>iminer: On the basis of examin<br>and manner stated. | owledge, death occurre<br>ation and/or investigation | d at the time, date and place<br>on, in my opinion, death occu | e, and due to the causured at the time, date | se(s) and manner a<br>a and place, and du | as stated.<br>le to the cause(s) |
| -                           | To the comp  | M                   | 29b. Signature and title of certifier   | 1 0.01   |  | 9c. License number   | 29d  | . Date signed (Mor                        | nth, Day, Year)                  |
|                             | . (  |                     | 30. Name and address of person who  | lado, MD, F  |  | D31419   |  | 2/27/05                                   |                                  |
|                             | 17   |                     | DAVID H. Mad  | doff Such  | rel PAUPA  | Blva. BALTI  | more MI                                      | ১.  |                                  |
|                             | Sta<br>Registi   |                     | 31. Date filed (Month, Day, Year) DEC 2 7   | 32. Segistrar's Sign   | dature front   |  |  |   |                                  |

DHMH 17 Rev 1/2001

|  |                | 1 - For<br>State<br>Registrar   | State of Ma  | ryland             |                                   | rtment<br>tificate           |                            |                                   | nd Me                   |                                  | giene                                  | 5                                       | +1709   |
|--|----------------|---|--|--------------------|-----------------------------------|------------------------------|----------------------------|-----------------------------------|-------------------------|----------------------------------|--|---|---|
| Physici<br>/Medio  |                | 1. Decedent's Name (First, Middle, Last   | J 1  | 18                 | TCI                               | 9LF                          | _                          |                                   |                         | Date of De.<br>Month             | 19 Z                                   | Year<br>2005                            | 3. Time of Death /608 M                         |
| Examir<br>Funeral<br>Director  | ner            | 212-46-3804   | EDICAL   | (In yrs. la        | st birthday) Yrs.                 | If Under 1                   | ALT<br>Year                |                                   | ORE                     | . Date of Birt                   | BALT                                   | 9. Birthp<br>Mar                        | CECTY  place (State or Foreign  ryland          |
| Maryland<br>f ehow   | ior            | Usual Residence of Decedent   10a. State   10b. County   Maryland   N/A   |  |                    | Town or Loc<br>Baltim             |                              |                            |                                   |                         |                                  |  | 1                                       | 10d. Inside City Limits 1X Yes 2 No             |
| death with the Maryland<br>ms 23a or 28s-1 show<br>man be notified at  | ai Director    | 10e. Street and Number 19 East Ostend St  | reet   |                    |                                   | 10f. Zip (                   | 2123                       | 30                                |                         |                                  | 10g. Citizen of                        | What Cour                               | •   |
| <u> </u>   | by Funeral     | 11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced  | 12. Was Decedent E Armed Forces? 1 Tyes 2 Ty Il Yes, Give Year or Dates: |                    | If                                | /as Decede<br>Yes, specif    | fy Cuban,                  | anic Orig<br>Mexican,<br>Specify: | in? (Specr<br>Puerto Ri | fy Yes or No<br>can, etc.)       | Bla                                    | ace - Americ<br>ack, White,<br>ify: Whi | etc.  |
| 21215-0036<br>d within 72 hours af<br>piene.<br>r then "naturel", or<br>the Medical Exerc  | Completed      | 15. Decedent's Edi<br>(Specify only highest grad<br>Elementary/Secondary (0-12)<br>12   | cation<br>le completed) College (1-4or 5-                                | +)                 | 16a. Decede<br>(Give k<br>life. D | ind of work<br>O NOT use     | done dur<br>retired)       |                                   | of working              |                                  | 16b. Kind of E                         |   | dustry<br>ndustry                               |
|  | To Be C        | 17. Father's Name (First, Middle, Last)  Joseph Schil   | ling   |                    |                                   |                              | 18                         | 8. Mother<br>Lill                 |                         |                                  | Maiden Suma<br>arts                    |   |   |
| Heal Heal  |                | 19a. Informant's Name/Relationship (T) Robert Douglas Met 20a. Mathod of Disposition  |  |                    |                                   | 0ste                         | nd St                      |                                   |                         | timore                           | er, City or Town , Mary1 20c. Location | and                                     | 21230   |
| iltimo   |                | 1 ☐ Burial 2 ☐ Cremation 3 ☐ I<br>4 ☐ Donation 5 ☐ Other (Specify,<br>21. Signature of Funery   Service Light   |  | cer                | y Cros                            | s Cem                        | etery<br>Address           | of Facility                       | 2-23-                   | -05                              | Baltimo                                | re,Ma                                   | aryland   |
| Departit. Departit. Import   |                | 23a and Enter the No. ase, or comp<br>shock, or heart fail ve. List only o  | Wayne Ust  | the death.         |                                   |                              |                            |                                   |                         |                                  |  | Maryl                                   | and 21230 Approximate Interval Between          |
| Salon, Medical Examiner bhysicien and street be executed the street by the purial-transit  | dicai Examiner | Immediate Cause (Final disease or condition resulting na death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | Due to (or as a d  | conseque           | Obst<br>ence of):                 | st                           | with<br>rive               | Peli                              | nona                    | xia<br>cy C                      | Diseas                                 | e                                       | Onset and Death ZO Min                          |
| ecords, P.O. Box 68/60, Iaw requires that the death certificate be executed as been signed by the attending physicien and 2 should be detached for use as the burial-transit | Physician/Med  | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown   | 23c. If yes, outcome of 1 Live birth 24 Pregnant at 19 Unknown           | 2 Fetal c          | death 3□                          | Ectopic pre<br>Other (spe    |                            |                                   |                         |                                  |  | ate of deliver                          | ery<br>Day Year                                 |
| rdS, P. quires that n signed by  | þ              | Part II. Other significant conditions co  | ntributing to death bu   | t not result       | ting in the und                   | derlying car                 | use given                  | in Part I.                        |                         | 23e. Did to                      |  | ntribute to th                          | he cause of death?                              |
| The<br>The<br>ate h  | Completed      |   |  |                    |                                   |                              |                            |                                   |                         | 24a. Was<br>autop<br>perfo       | an 24b.<br>isy<br>rmed?<br>2000 No     | Were autoprior to condeath?             | psy findings available<br>impletion of cause of |
| r VITAL Pryeicien: The is certificate director, pag  | To Be          | 25. Was case referred to medical examiner?  1 ☐ Yes 2 No  | Hospital:<br>1 ☐ Inpatier  | nt of Sale         | R/Outpatient                      | 3 🗆 DOA                      | 1 04                       |                                   |                         | Check only o                     | <i>ne)</i><br>lence 6 ⊡Ot              |   |   |
| on O' ing Ph After th Iuneral  |                | 27. Manner of Death  1. Natural 5 Pending 2 Accident investigation  | 28a. Date of Injun<br>(Month, Day  |                    | 28b. Time of<br>Injury            |                              | c. Injury at<br>Work?      |                                   | 28                      |                                  | lence 6 Ot                             |   | /)  |
| DIVISIC  To the Hospitel or Attenc within 24 hours after deatt To the Funerel Director; completely filled in by the 1  | Certification: | 3 Suicide 6 Could not be<br>4 Homicide determined   | 28e. Place of Inju<br>building, etc                                      | . (Specify)        | _                                 |                              |                            |                                   |                         | City or Tou                      | m, State)                              |   | al Route Number,                                |
| To the Hospitel or within 24 hours after To the Funerel Discompletely filled in  | Medical        | 29a. Certifier (Check only one)  1 Certifying Phy 2 Medical Exami   | sician: To the best o<br>ner: On the basis of<br>and manner stat         | examination        | ledge, death<br>on and/or inve    | occurred at<br>estigation, i | t the time,<br>in my opini | date and<br>ion, death            | place, and<br>noccurred | d due to the o<br>at the time, o | date and place                         | anner as st<br>, and due to             | ated.<br>the cause(s)                           |
| To the To the comp   | Σ              | 29b. Signature and the Reput of Legiting  | 1.   |                    |                                   |                              | License n                  |                                   | 4.1                     |                                  | 29d. Date sign                         |   |   |
| 554  |                | 30. Name and address of person who c  | ompleted cause of de   | MPP<br>atn (Item 2 | <del>23a) (Type,</del> P          | Print)                       | ØØ                         | \$6,                              | D\$ Z                   | 24                               | 1011                                   | 1/05                                    | TIMORE, 170                                     |
| Sta<br>Regist  |                | 31. Date liled (Month, Day, Year) DEC 2 7 200   | 32 Registra  | r's Signatu        | RCY A                             | 18050                        | CALC                       | ENT                               | ER,                     | 301 St                           | PACL F                                 | L,BA                                    | TIMORE, 170                                     |

Regina A. Marshall Unpend item 23,27, perfe, 3521,1/1/00 III Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene 05-8442 AKG State Registral Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician December 12, 2005 12:51 A M Regina Ann Marshall /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 611 Cedar Hill Road Brooklyn Park Anne Arundel If Under 1 Year II Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🖺 F 45 Director 218-80-9077 1-25-1960 MD Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28e-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Depertment of Health and Mental Hygiene. important: if Item 27 is marked other then "natural", or items 23a or 28e-f show any Injury or other traumatic event, the Modical Examiner must be notified at once. 1 ☐ Yes 2XQXNo Director Anne Arundel Brooklyn 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 611 Cedar Hill Road 21225 Funeral U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married ☐Yes 2 20No Baltimore, Maryland 21215-0036 White þ lf Yes, Give Year or Dates: 1 ☐ Yes 2 ☒ No Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Service Manager Maintenance 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဨ Fred Frampton Mary (unknown) 19a. Informant's Name/Relationship (Type, Print) Husband/ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 611 Cedar Hill Road; Brooklyn, MD 21225 Mr. Ellsworth F. Marshall ΙV 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Chesapeake Cremation | 12-20-2005 | Stevensville, MD 22. Name and Address of Facility Singleton Funeral Home, PA 21. Signature of Funeral Service Licenses Moi3571 Second Ave SW; Glen Burnie, MD 21061 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Complications of Chronic Alcoholism disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examine or Attending Physician: The law requires that the death certificate be executed use es the burial-transit resulting in death) Last Due to (or as a consequence of) Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 ☐ Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. Yes 2 □ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ page 2 should be Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ✓ Yes 2 □ No 24a. Was an autopsy performed? this certificete Yes 2□ No Be 25. Was case referred to medical examiner? 26. Place of Death | Check only one Hospital: 1 ☐ Inpatient Other 4 Nursing Home 5 Residence SCOOther (Specify) Et Scene 1 X Yes 2 No Certification; To 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours efter death

To the Funeral Director:
completely filled in by the 6 Could not be determined 3 ☐ Suicide Place of Injury - At home, larm, street, factory, office building, etc. (Specify) 28l. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated. the the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. December 15, 2005

State Registrar 2ADIUCUS
31. Date liled (Month, Day, Year)

DEC 2 7 2005

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Pegistrar's Signature

Division of Vital Records, P.O. Box 68760

|  |                     | Please Type or Print in Black In  State of Maryland / Dep.  1- For State Registrar Ce  |   | ental Hygie                             | 3  |
|--|---------------------|--|---|---|--|
| Physici  |                     | Dorothy Macciola  Macciola   |   | 2. Date of Death<br>Month<br>December 2 | Day Year   |
| /Medio<br>Examir<br>Funeral  |                     | 4a. Facility Name (If not institution, give street and number)  Gilchrist Center  5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)  | 4b. City, Town, or Location of Death TOWSON If Under 1 Year If Under 24 Hrs.                                  | 3. Date of Birth                        | 4c. County of Death  Baltimore  9. Birthplace (State or Foreign)                           |
| Director   | or                  | 213-10-5436 1 □ M 2 Ø F 89 Yrs.  Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Le  Maryland N/A Baltimor  | ocation   | eptember 1                              | (5), 1916 Mary land  10d. Inside City Limits  1   Wes 2   No                               |
| should be filed within 72 hours after death with the Maryland and Manial Hygiene and Manial Hygiene when them seemed to see a see a seement and the marked other then "neturel, or terms 23s or 28s-f show matter event, the Medical Exerciting must be notified at                            | ral Director        | 10e. Street and Number  1650 Woodbourne Avenue   | 10f. Zip Code<br>21239  | ι                                       | . Citizen of What Country?   |
| hours after de   | d by Funeral        | 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ Mo If Yes, Give Year or Dates:   | Was Decedent of Hispanic Origin? (Spec<br>If Yes, specify Cuban, Mexican, Puerto R<br>1 ☐ Yes 2 🂢 No Specify: |   | 14. Race - American Indian,<br>Black, White, etc.  Specify: White                          |
| led within 72 lygiene.   | Completed           | (Specify only highest grade completed)  Elementary(Secondary (0-12) College (1-4or 5+)  Opera  |   | P                                       | b. Kind of Business/Industry  Phone Company  |
| should be fill and Mental H marked ott   | To Be               | 17. Father's Name (First, Middle, Last)  Theodore Bowinkelman  19a. Informant's Name/Relationship (Type, Print)  19b. Maili  | 18. Mother's Name Gladys Goodw  ng Address (Street and Number or Rural  | in                                      |  |
| pormit. Peges 1 end 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "naturel", or iteme 23a or 28a-1 show supering or other treumatic event, the Medical Examination at an once.            |                     | 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State   | 6 Perthshire Drive Oak position (Name of matory or other place) rvice Corp. 12/28/0                           | te 20                                   | orth Carolina 27310 c. Location - City or Town, State  WSON Maryland                       |
| permit. Departr Imports ony inju   |                     | 21. Signature of Funeral Service Licensee Christina L Hiltons  Chestra A Hello  23a. Part 1. Enter the disease, or complications that caused the death. Do not en  | 2 Name and Address of Sacility Inc.<br>5305 Harford Road Balt   | imore Mary                              | yland 21214  |
| ate be executed  Wedical Examiner  Thysicien and The burial-transit  | licai Examiner      | shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  C |   |   | Interval Between Onset and Death   |
| requires that the death certificate been signed by the ettending phys should be detached for use as the  | Physician/Medic     |  | □Ectopic pregnancy<br>□ Other (specify)   |   | 23d. Date of delivery  Month Day Year  |
| w requires that been signed be deta  | þ                   | Part II. Other significant conditions contributing to death but not resulting in the u   |   | 23e. Did tobac                          | cco use contribute to the cause of death?  |
| ion: The law<br>rtificate hes b  | se Completed        | 25. Was case referred to medical   | 26. Place of Death  |   | 24b. Were autopsy findings available prior to completion of cause of death?  No 1 Yes 2 No |
| To the Hospital or Attending Physicien: The law requires that the death certificate within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the ettending physicompletely filled in by the funeral director, page 2 should be detached for use as the | Certification: To B | examiner?  1   | of 28c. Injury at Work?  M 1 ☐ Yes 2 ☐ No   | ld. Describe how                        | et and Number or Rural Route Number.   |
| the Hospit<br>nin 24 hours<br>the Funere<br>npletely fille   | Medical C           | 29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, deat Check only one)  Certifying Physician: To the best of my knowledge, deat Check only one)  Medical Examinar: On the basis of examination and/or in and manner stated.  | ivestigation, in my opinion, death occurred   | I at the time, date                     | and place, and due to the cause(s)   |
| T will   | -                   | 29b. Signature and title of certifier  30. Name and address of person who completed cause of death (Item 23a) (Type,   | D S 8 3 0 3   | D.                                      | eceinlow 24 2005   |
| Sta<br>Regist  |                     | 31. Date filed (Month, Day, Year) DEC 2 7 2005   | V. Charles Sr Bel   | ltrive                                  | Date signed (Month, Day, Year)  CCLIMSU ZY 2005  M) 2/204                                  |
|  | 004                 | COOL PROPERTY NO. 10   |   |   |  |

|                   |  |                | 1 - For State of Maryla  |                                       | artment of H                                      |  |                                      | iene<br>2005                       | j 4                         | 1712   |
|-------------------|--|----------------|--|---------------------------------------|---|--|--------------------------------------|------------------------------------|-----------------------------|--|
|                   | A g  | N.             | Decedent's Name (First, Middle, Last)  |                                       |   |  | 2. Date of Dear                      |                                    |                             | 3. Time of Death                                   |
|                   | Physici  |                | William L Mace Sir.  |                                       |   |  | Month<br>i 2                         | Day<br>Qu (                        | Year                        | 2:15 AM  |
|                   | /Medi<br>Examir  |                | 4a. Facility Name (If not institution, give street and number)   |                                       | 4b. City, Town, or                                | Location of Death  |                                      | 4c. County                         |                             | 4.10   |
|                   |  |                | John Homins Bayview  |                                       | Bal   | more   |                                      | Bel                                | tim.                        | \ ~\@  |
|                   | Funeral  | A              | Social Security Number     6. Sex     7. Age (In yr  | s. last birthday)                     | If Under 1 Year                                   | If Under 24 Hrs.   | 8. Date of Birth                     |                                    | 9. Birthpl                  | ace (State or Foreign                              |
|                   | Director   |                | 220-30-7932   ¹Ѿ∕М <sup>2□</sup> F   «   | 70 Yrs.                               | Months Days                                       | Hours Min.   | (Month, Day,                         |                                    | Coun                        | vland  |
|                   | ٦ ي  |                | Usual Residence of Decedent  |                                       |   |  |                                      |                                    | 1701                        | утапи  |
|                   | aryla<br>hov   | پ ا            | 10a. State 10b. County 10c. (  | City, Town or Lo                      |   |  |                                      |                                    | 10                          | Od. Inside City Limits                             |
|                   | the Maryland<br>r 28e-f ahow   | cto            | Maryland Baltimore   |                                       | Dur   | ndalk  |                                      |                                    |                             | 1 ☐ Yes ŽŽXNo                                      |
|                   | ith th   | Director       | 10e. Street and Number   |                                       | 10f. Zip Code                                     |  | 1                                    | 0g. Citizen of V                   | /hat Count                  | try?   |
|                   | 72 hours after death with the Maryland<br>natural", or Items 23a or 28e-f ahow<br>acal Examiliter must be notified at  |                | 1703 Bayard Ave.   |                                       | 2   | 21222  |                                      | United                             | Stat                        | es   |
|                   | e de   | Funerai        | 11. Marital Status 12. Was Decedent Ever in Armed Forces?  | U.S. 13.                              | Was Decedent of Hi<br>If Yes, specify Cuba        | ispanic Origin? (Sp<br>n, Mexican, Puerto  | ecify Yes or No-<br>Rican, etc.)     |                                    | - America                   |  |
| 36                | s afte   | by F           | 1 ☐ Never Married 2 ☑ Married 1 ☑ Yes 2 ☐ No If Yes, Give  |                                       | 1 ☐ Yes 2 ☑ No                                    |  |                                      | Specify                            |                             |  |
| 21215-0036        | ural   |                | 3 Widowed 4 Divorced Year or Dates:  |                                       |   |  |                                      |                                    | W.                          | hite   |
| 15                | "nat   | Completed      | 15. Decedent's Education<br>(Specify only highest grade completed)   | (Give                                 | dent's Usual Occupa<br>kind of work done d        | lurina most of work  | ing                                  | 16b. Kind of Bu                    | siness/Ind                  | ustry  |
| 12                | d within<br>piene.<br>r than "   | Ę.             | Elementary/Secondary (0-12) College (1-4or 5+)   |                                       | DO NOT use retired,                               |  |                                      | ToT a multi-sea                    | 77                          |  |
| 7                 | lled<br>1ygi   | ပိ             | 12 Years  17. Father's Name (First, Middle, Last)  | Sec                                   | urity Gua   | 18. Mother's Name  | a /First Middle A                    |                                    |                             | ectric Co.   |
| an                | Q 25 Q   | Be             | John Mace  |                                       |   |  | McClel1                              |                                    | 9/                          |  |
| 2                 | 2 should be f<br>and Mental H<br>le marked of<br>raumatic eve  | 2              | 19a. Informant's Name/Relationship (Type, Print)   | 10h Maifie                            | a Address (Carress                                |  | _                                    |                                    |                             |  |
| Maryland          | s 1 and 2 should<br>f Health and Mer<br>item 27 le marke<br>other traumatic  |                | Mrs. Dolores V. Mace (Wife)  |                                       | ng Address <i>(Str</i> ee <i>t a</i><br>03 Bayard |  |                                      |                                    |                             | Code)<br>222                                       |
|                   | s 1 an<br>of Heal<br>item 2<br>other   |                |  | Place of Dispo                        |   |  |                                      | 20c. Location -                    |                             |  |
| ٥                 | ages<br>of of<br>or or   |                | 1 Buriat 2 Cremation 3 Removal from State  | cemetery, cren                        | natory or other place                             | э)   |                                      |                                    | •                           |  |
| altimore,         | rtmer<br>rtant   |                |  |                                       | Mill Mem.   |  |                                      |                                    |                             |  |
| Ba                | permit. Pages<br>Department of<br>Important: If is<br>any injury or o  |                | 21. Signature of Funeral Service Licensee  |                                       | Name and Addres<br>ouda-Ruck                      |  |                                      |                                    |                             |  |
| ,                 |  |                | 23a Part 1 Enter the disease or complications that accord the de   | 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 | 922 Wise  | Ave. Du  | ndalk, M                             | laryland                           |                             |  |
|                   |  |                | 23a. Part1. Enter the disease, or complications that caused the deshock, or heart failure. List only one cause on each line. | ath. Do not enti                      | er the mode of dying                              | g, such as cardiac i   | or respiratory arre                  | est,                               | i                           | Approximate<br>Interval Between<br>Onset and Death |
|                   | Physician  |                | Immediate Cause (Final disease or condition resulting in death)  PER   | ames                                  | 5/-   |  |                                      |                                    |                             | 45 mm  |
|                   | /Medical<br>Examiner   |                | Due to (or as a conse  | equence of):                          |   |  |                                      |                                    |                             |  |
| *                 |  | -              | Sequentially list conditions, if any, leading to immediate  b. Pulm  Due to (or as a conse                                   | remonor                               | more  |  |                                      |                                    |                             |  |
| H                 | ed<br>sit  | nin            | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury                  | equence or):                          |   |  |                                      |                                    |                             |  |
| ٢                 | and<br>and   | Examiner       | that initiated events resulting in death) Last   | inuence of):                          |   |  |                                      |                                    |                             |  |
| 8760,             | tate be executed by sician and the burial-transit  | a E            | 330 10 (0) 43 4 001130   | rquerice or).                         |   |  |                                      |                                    |                             |  |
| 387               | certificate be<br>Iding physicia<br>Ise as the bur   | dical          | d  |                                       |   |  |                                      |                                    |                             |  |
| 9 X               | leath certifica<br>ettending ph<br>i for use as th   | Physician/Me   | IF FEMALE: 23c. If yes, outcome of pregi   | nanov                                 |   |  |                                      |                                    |                             |  |
| Вох               | ath<br>tter  | lan            | in the past 12 months?   | tal déath 3 🗆                         | Ectopic pregnancy                                 |  |                                      | 23d. Date<br>Mon                   | of deliver                  | y<br>Day Year                                      |
| P.O.              | 0 0 0  | ysic           | 1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of 9 ☐ Unknown 9 ☐ Unknown   | death 5                               | Other (specify)                                   |  |                                      |                                    |                             | •  |
|                   | requires that the de<br>een signed by the e<br>nould be detached f   | 4              | Part II. Other significant conditions contributing to death but not re   | sulting in the un                     | nderiving cause give                              | n in Part I  | 23e Did tob                          | acco use contri                    | hute to the                 | cause of death?                                    |
| ds,               | 8 50   | व              | CHE  | <b>3</b>                              | .ac.,g caree g.ce                                 | The state of the s |                                      |                                    | 3 🗆 Probai                  |  |
| ŏ                 |  | ete            |  |                                       |   |  |                                      |                                    |                             |  |
| of Vital Records, | e law<br>has b   | Completed by   | GI Bieal   |                                       |   |  | 24a. Was an autopsy                  | / pr                               | ior to com                  | sy findings available pletion of cause of          |
| a                 | n: The<br>icete h  |                |  |                                       |   |  | perform<br>1 Tes 2                   |                                    | eath?<br>□Yes 2             | Z 140  |
| Z.                | Physician:<br>this certific<br>ral director,   | Be             | 25. Was case referred to medical examiner?   |                                       | OH-   | 26. Place of Death   | (Check only one                      | )                                  |                             |  |
| of                | Phys<br>this<br>rat di   | 2              | 1 Tes 2 PNO 1 I Mpatient 2   | 28b. Time of                          |   | 4   Nursing Ho   | me 5 Resider                         |                                    |                             |  |
| L C               | Jing<br>After<br>fune  | io l           | 1 ☑Natural 5 ☐ Pending (Month, Day Year)   | Injury                                | 28c. Injury<br>Work                               |  | 28d. Describe ho                     | w injury occurre                   | d                           |  |
| Division          | Attending r death. ector: After by the fune  | Certification: | 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be  |                                       |   | es 2 No  | 201                                  |                                    |                             |  |
| Ì                 | or A<br>after<br>Direct<br>in by   | it.            | 4 Homicide  4 Homicide  4 Homicide  28e. Place of Injury - At building, etc. (Spec   | nome, rarm, stre                      | eet, factory, office                              |  | 28f. Location (Str.<br>City or Town, | eet and Numbe<br>State)            | r or Rural I                | Route Number,                                      |
| _                 | Hospitel   |                | 29a. Certifier 1 Certifying Physician: To the best of my kn  |                                       |   |  |                                      |                                    |                             |  |
|                   | Hos<br>Fun<br>Fun  | lica           | (Check only 2 Medical Examiner: On the basis of examin   | iowledge, death<br>lation and/or inv  | occurred at the time<br>estigation, in my opi     | e, date and place, a<br>inion, death occurr  | and due to the cared at the time, da | use(s) and man<br>te and place, ar | ner as stat<br>nd due to ti | ted.<br>he ca <i>us</i> e(s)                       |
|                   | To the Hospitel or Attending Physician: The law within 24 hours after death. To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2. | Medicai        | one) and manner stated.  29b. Signature and title of certifier   |                                       | 29c. License                                      |  |                                      |                                    |                             |  |
|                   | F 3 F 8  |                | Al and   |                                       |   |  | 29                                   | d. Date signed                     |                             |  |
|                   |  | -              | Tel min  |                                       | 100   | 142  |                                      | 12/20                              | 7/0                         | 5  |
|                   | 4+1  |                | 30. Name and address of person who completed cause of death (fte   | m 23a) (Type, F                       | Print)  | - 0  |                                      | 00                                 |                             |  |
| V                 | 1 ' 1  | 0              | SANDERU SHAH 4940 E 31. Date filed (Month, Pay, Year) 32. Segistrar's Sign   | rature                                | N AVENUE  | t BAL  | timoro                               | ITID                               | 2/2                         | 24   |
|                   | Sta<br>Registr   | ar             | 31. Date filed (Month, Pax Year) 7 2005 32. Tegistrar's Sign   | B. A                                  | when  |  |                                      |                                    |                             |  |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 15 1 - For State Registrar Certificate of Death Rea. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month Year **MASSOUDA** G Physician BENOIT 7:35 AM DECEMBER 2005 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** BALTIMORE C

If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. HOSPITAL 01-BALTIMORE 8. Date of Birth 05/05/1925 Birthplace (State or Foreign Country)
 EGYPT 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 1 M 2 □ F 80 038-38-8400 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f ehow or other traumatic event, the Medical Examiner must be notified at 1 Yes 2 No BALTIMORE N/A MD Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21209 2901 FALLSTAFF ROAD APT. 403 U.S.A. 23a 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☐ No Specify: 14. Race - American Indian, "natural", or iteme Black, White etc. WHITE 1 Never Married 2 Married Specify þ 3 ☐ Widowed 4 ☑ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) and Mental Hygiene. College (1-4or 5+) 5+ Elementary/Secondary (0-12) **FURNITURE** DESIGNER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 1 and 2 should be Health and Mental LICHAA MASSOUDA REGINA GABRIEL 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 to Department of Health ar Importent: If Item 27 leany injury or other trauonce. 4305 SCOTCH ROSE COURT-BALTIMORE, MD 21208 WARREN MASSOUDA/BROTHER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 12/26/2005 BALTIMORE, MD CHIZUK AMUNO CONG. 21. Signature of Funeral Service Licensee 22. Name and Address of Escility SOL LEVINSON & BROS., INC. ترص 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician CARDIOGENIC SHOCK /Medical Due to (or as a consequence of): CAD Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine attending physicien and for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 1 Live birth 2 ☐ Fetal death in the past 12 months?
1 Yes 2 No Month Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part If. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. þ Hemodialycis 1 Tyes 2 No 3 Probably 4 Unknown should should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificete has t irector, page 2 s autopsy performed 1 Yes 2 No 1 ☐ Yes 20 No 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this : After this funeral of Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Injury at Work? Certification: 1 Natural 5 Pending 1 Tes 2 No investigation death. 2 Accident Director: d in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral C 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier RES - 000 December 25, 2005 amil wordharson 3 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WADHAWAN SINAL HOSPITAL OF MIS LOMIL 31. Date filed (Month, Day, Year) 32 Registrar's Signature State

Registrar

7 2005

|             |  |                  | 1 - State<br>Registrar <b>Amend Item</b>  | State of Maryla   | •                       |  |                                    | nd Menta                             | , ,                                    | ne<br>2.005          | 14 17 14   |
|-------------|--|------------------|---|---|-------------------------|--|------------------------------------|--------------------------------------|--|----------------------|--|
|             | Diii   |                  | Decedent's Name (First, Middle, Last)   | )   | 71 1/10                 | 700 JH                                 |                                    | MAC                                  | te of Death                            | Day V                | 3. Time of Death   |
|             | Physicia<br>/Medic   |                  | EMORY OLIVER NO   |   |                         |  |                                    | DEC                                  | EMBER                                  | 24, 20               | 05 9:20 A.M.   |
|             | Examin   | er               | 4a. Facility Name (If not institution, give   | ·   |                         | 4b. City, Town,                        |                                    | Death                                |  | 4c. County of        |  |
|             | Funeral  |                  | 8142 GLEN GARY R  |   | . last birthday)        | PARKV<br>If Under 1 Year               | If Under 24                        | 4 Hrs. 8. Da                         | te of Birth                            | BALTI                | Birtholace (State or Foreign                                 |
| Ш           | Director   |                  | 215-24-3 <del>477</del>   | XM 2□F 76   | Yrs.                    | Months Days                            | Hours                              | Min. (M                              | te of Birth<br>onth, Day, Ye<br>17/192 | 29 1                 | Country)<br>MARYLAND   |
|             | and and  | }                | Usual Residence of Decedent  10a. State 10b. County   | 10c. C  | ity, Town or Lo         | ocation                                |                                    |                                      |  |                      | 10d. Inside City Limits                                      |
|             | Maryl<br>-1 sho  | tor              | MD BALTIMO  | RE  | PARKVI                  | LLE                                    |                                    |                                      |  |                      | 1 ☐ Yes 2 ☐ Xio  |
|             | th the<br>or 28a<br>e noti   | irec             | 10e. Street and Number  |   |                         | 10f. Zip Code                          |                                    |                                      | 10g.                                   | Citizen of Wha       | at Country?  |
|             | be filed within 72 hours after death with the Marylan ital Hygliene. id other then "natural", or items 23e or 28a-1 show or other then "natural", or event, it is Medical Examiner must be notified at | Funeral Director | 8142 GLEN GARY RO   |   |                         | 2123                                   |                                    |                                      |  | USA                  |  |
|             | ter de   | une              | 11. Marital Status 1 ☐ Never Married  | 12. Was Decedent Ever in the Armed Forces? 1 □XYes 2 □ No | J.S. 13.                | Was Decedent of<br>If Yes, specify Cub | Hispanic Origii<br>oan, Mexican, I | n? (Specify Ye<br>Puerto Rican,      | etc.)                                  |                      | American Indian,<br>White, etc.                              |
| 920         | urs af   | by               | 3 Widowed 4 Divorced  | If Yes, Give<br>Year or Dates: WWI]                       |                         | 1 ☐ Yes 2 X No                         | Specify:                           |                                      |  | Specify:             | WHITE  |
| 21215-0036  | 72 ho<br>'natur  | Completed        | 15. Decedent's Edu<br>(Specify only highest grad  |   | (Give                   | dent's Usual Occu                      | during most o                      | of working                           | 168                                    | . Kind of Busin      | ness/Industry  |
| 121         | within<br>ene.<br>than '   | idmo             | Elementary/Secondary (0-12)   | College (1-4or 5+)  |                         | DO NOT use retire<br>F <b>I</b> GHTER  | od)                                |                                      |  | CITY OF              | F BALTIMORE  |
| д<br>2      | Hygid<br>other<br>ent, I   | Be Cc            | 8TH GRADE  17. Father's Name (First, Middle, Last)  |   |                         |  | 18. Mother's                       | s Name (First,                       | Middle, Mai                            | den Sumame)          |  |
| /lan        | should be filed within 72 hours after death with the Maryland nd Mental Hyglene. Is marked other than "natural", or Items 23e or 28a-f show unatic event, I's Modical Exacilier must be neilified at   | To B             | EMORY O. NORRIS   |   |                         |  | ANNA                               | A KAUFM                              | IANN                                   |                      |  |
| Maryland    | 2 sh<br>and<br>ls m  |                  | 19a. Informant's Name/Relationship (Ty  |   |                         | ng Address (Stree                      |                                    |                                      |  | ·                    |  |
|             | 1 and 1<br>Health tam 27   |                  | MARGARET C. NORRI.  20a. Method of Disposition  | · <del>'</del>  | Place of Disp           | 2 GLEN G                               | 1                                  | Date                                 | TIMORE<br>200                          | •                    | 21234<br>ly or Town, State                                   |
| altimore,   | Pages<br>nent of<br>int: If it<br>iry or o   |                  | 1 Burial 2 □ Cremation 3 □ P 4 □ Donation 5 □ Other (Specify)   |   | -                       | matory or other pla<br>MEM。PAI         |                                    | 12/28/2                              | 005 H                                  | ILLENDA              | ALE. MD  |
| a           | permit. Page<br>Department of<br>Important: If<br>any injury or<br>once.   |                  | 21. Signatur of Funeral Service Licens  | -   |                         |  | ess of Facilit¶                    | THE JOH                              |  |                      | HOME, P.A.   |
| <u> </u>    | \$ 5 E E S   |                  | Beather N   | Harju   |                         | 521 LOCH                               |                                    |                                      |  | N, MD                | 21286  |
| П           |  |                  | 23a. Part 1. Enter the disease, or complete shock, or heart failure. List only or                           | ications that caused the deane cause on each line.        | ath. Do not en          | A B                                    |                                    | 1 0                                  |  |                      | Approximate<br>Interval Between<br>Onset and Death           |
|             | Physician /Medical   |                  | Immediate Cause (Final disease or condition resulting in death)   | Due to (or as a conse                                     | TC                      | relain                                 | oma.                               | to L                                 | iver                                   | ·<br>                | 7 mon.   |
|             | Examiner   |                  | Consectable that was distance   | b   | quence oi).             |  |                                    |                                      |  |                      |  |
| Н           | D #  | iner             | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | Due to (or as a conse                                     | quence of):             |  |                                    |                                      |  |                      |  |
|             | xecute<br>and<br>al-trans  | Examiner         | that initiated events resulting in death) Last  | Due to (or as a conse                                     | quence of):             |  |                                    |                                      |  |                      |  |
| 760,        | The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit                                     | icai E           | (   | d   |                         |  |                                    |                                      |  |                      |  |
| 9           | rtificat<br>ng phy<br>as the   |                  | IF FEMALE:  |   |                         |  |                                    |                                      |  |                      |  |
| Вох         | eath certific<br>attending p   | ian/I            | 23b. Was decedent pregnant in the past 12 months?   | 3c. If yes, outcome of pregr<br>1☐Live birth 2☐Fet        | aldeath 3[              | Ectopic pregnanc                       | у                                  |                                      |  | 23d. Date o<br>Month | f delivery<br>Day Year                                       |
| 0           | res that the de<br>signed by the a<br>be detached t  | Physician/Med    | 1 ☐ Yes 2 ☐ No<br>9 ☐ Unknown   | 4□Pregnant at time of<br>9□Unknown                        | death 5                 | Other (specify) _                      |                                    |                                      |  |                      |  |
| ري<br>م     | s that<br>ned b<br>e deta  | by Pr            | Part II. Other significant conditions con   | ntributing to death but not re                            | sulting in the u        | ınderlying cause gi                    | ven in Part I.                     | 23                                   | e. Did tobac                           | co use contribu      | ite to the cause of death?                                   |
| Side        | w require<br>been sig<br>should b  | ted t            |   |   |                         |  | ÷ = -                              |                                      | 1 🗆 Yes                                | 2 No 3[              | ☐ Probably 4 ☐Unknown  |
| Records,    | e law r<br>has be<br>je 2 sh   | Completed        |   |   |                         |  |                                    | 24                                   | la. Was an<br>autopsy                  | prio                 | re autopsy findings available<br>r to completion of cause of |
|             |  |                  |   |   |                         |  |                                    |                                      | performed<br>Yes 2                     |                      | Yes 2□ No  |
| Vita        | ysicial<br>is certii<br>directo  | To Be            | 25. Was case referred to medical examiner?  1 Tyes 2 No   | Hospital: 1  Inpatient 2                                  | ∃ ER/Outpatie           | nt 3 DOA Ot                            | hor                                | of Death <i>(Ched</i><br>sing Home 5 |  | e 6 Other (          | (Specify)  |
| J O         | Attanding Physician: r death. actor: After this certifics by the funeral director.   |                  | 27. Manner of Death 1 Natural 5 ☐ Pending   | 28a. Date of Injury<br>(Month, Day Year)                  | 28b. Time o             |  |                                    |                                      | **                                     | njury occurred       | 2,200.97   |
| Siol        | r Attandir<br>er death.<br>ractor: Ai<br>by the fu   | catic            | 2 Accident investigation 3 Suicide 6 Could not be   |   |                         | M 1                                    | Yes 2 No                           |                                      |  | A                    | 0.10.14.1  |
| Division of | i ji fe  | Certification:   | 4 Homicide determined   | 28e. Place of Injury - At building, etc. (Spec            | nome, farm, st<br>eify) | reet, factory, office                  |                                    |                                      | ty or Town, S                          |                      | or Rural Route Number,                                       |
|             | To tha Hospital or within 24 hours after To tha Funaral Dir completely filled in   |                  | 29a. Certifier 1 Certifying Phy   | sicien: To the best of my kr                              | nowledge, dea           | th occurred at the t                   | ime, date and                      | place, and du                        | e to the caus                          | e(s) and manne       | er as stated.  |
|             | To tha Howithin 24 I   | Medical          | one)  | ner: On the basis of examinand manner stated.             | iation and/or ir        |  |                                    | occurred at th                       |  |                      |  |
|             | With To T  | 2                | 29b. Signature and title of certifier   |   |                         |  | se number                          |                                      |  | _                    | Month, Day, Year)  |
| 1           | 11   |                  | 30. Name and address of person who  | mpleted cause of death (Ite                               | m_23a) (Tvna            |  | >15546                             | ^.                                   | 7                                      | SC 4 (               | , DUS  |
| 5           | 10   |                  | Charles Predoott  | 10 560 Lo   | ch Ra                   | en Au                                  | e. Ba                              | eltimo                               | Mi, sof                                | D 212                | ,2005  |
|             | Sta  |                  | 31. Date filed (Month Day, Year) UEC 2 7 20   | 32. Tegistrar's Sign                                      | nature                  | and s                                  | ,                                  |                                      |  |                      |  |
|             | Registi  | ar               | 3 - 7 20  | A PROPERTY OF   | No. The                 |  |                                    |                                      |  |                      |  |

DHMH 17 Rev 1/2001

| 833                 | м э. м<br>8  | TIAT             | Unpend item#2.  | <b>3a,27, perME,G850, 1</b><br>State of Maryland / De  | partment of Health and M   | i <b>Copies Ar</b><br>ental Hygiei             | e Legible.                                   | 1 1 -7 1 5   |
|---------------------|--|------------------|---|--|--|--|--|--|
|                     |  | •                | For<br>State<br>Registrar   |  | ertificate of Death  | Reg.   | 4000   | 41/15  |
|                     |  |                  | 1. Decedent's Name (First, Middle, Last)  |  |  | 2. Date of Death<br>Month                      | Day Year                                     | 3. Time of Death                                   |
|                     | Physici<br>/Medic  |                  | William   | J. Nine  |  |  | 10, 2005                                     | 1235 P M   |
|                     | Examin   |                  | 4a. Facility Name (If not institution, give   |  | 4b. City, Town, or Location of Death   |  | 4c. County of Death                          |  |
|                     |  |                  | 7 VIRGINIA AVENUE   |  | CUMBERLAND   |  | ALLEGANY                                     |  |
|                     | Funeral<br>Director  |                  | 5. Social Security Number 6. Sec. 217–42–7151 X   | 7. Age (In yrs. last birthd.   | Months Davs Hours Min.   | 8. Date of Birth<br>(Month, Day, Ye<br>DEC 21, | ar) Coui                                     | place (State or Foreign<br>htry)<br>yland          |
|                     | and and  |                  | 10a. State 10b. County  | 10c. City, Town or   | Location   |  |  | IOd. Inside City Limits                            |
|                     | Mary   | ģ                | Maryland Allegan  | V  | Cumberland   |  |  | 1 ☐ Yes 2X No                                      |
|                     | 7.28e  | irec             | 10e. Street and Number  |  | 10f. Zip Code  | 10g.   | Citizen of What Cou                          | ntry?  |
|                     | 23a C  | Funeral Director | 7 Virginia Avenue   | , Apt. 1   | 21502  |  | USA  |  |
|                     | ge dea   | Iner             | 11. Marital Status  | 12. Was Decedent Ever in U.S. 1<br>Armed Forces?   | <ol> <li>Was Decedent of Hispanic Origin? (Spe<br/>If Yes, specify Cuban, Mexican, Puerto F</li> </ol> | cify Yes or No-<br>Rican, etc.)                | 14. Race - Americ<br>Black, White,           |  |
| õ                   | or it  | 딧                | 1 Never Married 2 Married   | 1 ☐ Yes 2 🔯 No<br>If Yes, Give   | 1 ☐ Yes 2 🗓 No Specify:  |  |  | hite   |
| Š                   | 72 hours after death with the Maryland<br>natural, or items 23s or 28s-1 show<br>disal Examiner must be notitled at  | d by             | 3 Widowed 4 Divorced  | Year or Dates:   |  | 100  |  |  |
| ည်                  | n 72   | Completed        | 15. Decedent's Edu<br>(Specify only highest grade   | completed) (G  | icedent's Usual Occupation<br>ive kind of work done during most of workir<br>e. DO NOT use retired)    | ng 166   | . Kind of Business/In                        | dustry   |
| 2                   | filed within<br>Hygiene.<br>other then "<br>ent, the Med   | E                | Elementary/Secondary (0-12)   | College (1-4or 5+)   | Shoe Salesman  |  | Footwear                                     |  |
| ğ                   | Hygi<br>other  | BeC              | 17. Father's Name (First, Middle, Last)   |  |  | (First, Middle, Maid                           |  |  |
| Maryland 21215-0036 | Aenta<br>Aenta<br>rked<br>rice   | To 8             | Russell Joseph N  | line   | Mild   | red Mary 1                                     | Rizer  |  |
| a<br>Z              | 2 should be f<br>and Mental h<br>ie marked of<br>aumatic ever  |                  | 19a. Informant's Name/Relationship (Ty  |  | ailing Address (Street and Number or Rura  |  |  | Code)  |
|                     | is 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hygiene.  The marked other than "natural", or Iteme 23a or 28a-1 ehow other traumatic event, the Madical Exeminar must be notified at |                  | Dorothy E. Linn/S   | The second secon | 7 Beach View Street  | -  | VA 23503                                     |  |
| ore                 | ges 1<br>it of Ho<br>if iter<br>or oth   |                  | 20a. Method of Disposition 1 ☐ Burial 2 ☒ Cremation 3 ☐ R   | comoton:   | sposition (Name of Derematory or other place)  | ate 20c.                                       | Location - City or To                        | own, State   |
| Ě                   | Pag<br>ment<br>ant:<br>lury c  |                  | 4 ☐ Donation 5 ☐ Other (Specify)  | Metro Cr   | rematory, Inc. 12/21   |  | altimore,                                    |  |
| Baltimore,          | permit. Pages 1<br>Department of H<br>important: if ite<br>any injury or ot<br>once.   |                  | 21. Signature of Funeral Service License  | George MacNabb   |  |  | Society of                                   |  |
|                     | 70 = 4 d   |                  | seoge c. /  | alle   | 299 Frederick Roa  |  | nore, MD 2                                   |  |
| н                   |  |                  | shock, or heart failure. List only or   | cations that caused the death. Do not no cause on each line.   | enter the mode of dying, such as cardiac or  | r respiratory arrest,                          |  | Approximate<br>Interval Between<br>Onset and Death |
|                     | Physician<br>/Medical  |                  | Immediate Cause (Final disease or condition resulting in death)   |  | Cardiovascular Disc  | ease   |  |  |
|                     | Examiner   |                  |   | Due to (or as a consequence of):   |  |  |  |  |
|                     |  | ē                | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | Due to (or as a sonsequence of).   |  |  |  |  |
|                     | uted<br>d<br>ansit   | Examin           | cause. Enter Underlying Cause (Disease or injury that initiated events                                      |  |  |  |  |  |
| Ď                   | be executed<br>sicien and<br>burial-transit  | Exa              | resulting in death) Last  | Due to (or as a consequence of):   |  |  |  |  |
| 1760,               | The law requires that the death certificate be executed to has been signed by the attending physicien and page 2 should be detached for use as the burial-transit  | cai              |   | l  |  |  |  |  |
| 99                  | leath certificate<br>attending phys<br>ifor use as the   | Physician/Medi   | IF FEMALE:  |  |  |  |  |  |
| Вох                 | ath ce<br>ttendi   | an/l             | 23b. Was decedent pregnant in the past 12 months?   |  | 3 Ectopic pregnancy  |  | 23d. Date of deliver                         | ory<br>Day Year                                    |
|                     | the a  | /s c             | 1 Yes 2 No<br>9 Unknown   | 4□Pregnant at time of death<br>9□Unknown   | 5 Other (specify)  |  | WG/III                                       | Day Foat   |
| о.<br>О             | that the de<br>led by the a<br>detached t  |                  | Part II. Other significant conditions cor   | atributing to death but not resulting in th  | a underlying cause given in Part I.  | 23e. Did tobacc                                | o use contribute to ti                       | he cause of death?                                 |
| ds,                 | signed<br>signed<br>d be de  | d by             | •   |  |  | 1 ☐ Yes  |  | pably 4 □Unknown                                   |
| of Vital Records,   | w requir<br>been s<br>should   | Completed        |   |  |  | 24a. Was an                                    | 24h Were auto                                | neu findinge available                             |
| Ř                   | The lav  | E                |   |  |  | autopsy  | ?   death?                                   | psy findings available<br>mpletion of cause of     |
| ā                   | icion: T<br>cortificet<br>rector, pe   | ပိ               | 25. Was case referred to medical  |  | 26. Place of Death   | Yes 2  | No 1 Yes                                     | 2 No   |
| >                   | Physicion: The<br>r this certificete hi<br>ral director, page  | To B             | examiner?   | lospital:<br>1 ☐ Inpatient 2 ☐ ER/Outpa  | 0  |  | 6 XOther (Specil                             | SCENE  |
|                     | ਦੇ ਦੁਲ   |                  | 27. Manner of Death   | 28a. Date of Injury (Month, Day Year) 28b. Time  | e of 28c. Injury at 2  | 8d. Describe how in                            |  | // DOLLINE   |
| 0                   | Attending I<br>r death.<br>ector: After<br>by the funer  | atlo             | 1 Accident 5 Pending 2 Accident investigation   | (Month, Bay Your)  | M 1 Yes 2 No   |  |  |  |
| Division            | or Attendation of Director:  | Certification:   | 3 Suicide 6 Could not be<br>4 Homicide determined   | 28e. Place of Injury - At home, farm, building, etc. (Specify)   | street, factory, office 2  | 8f. Location (Street<br>City or Town, St       | and Number or Rura                           | al Route Number,                                   |
|                     | Itaio<br>Irs afi<br>Irai Di  |                  |   |  |  |  |  |  |
|                     | Hosp<br>4 hou<br>Fune<br>Fely fi   | edical           | (Check only 2X Medical Examin   | ner: On the basis of examination and/o   | eath occurred at the time, date and place, a<br>r investigation, in my opinion, death occurre          | nd due to the cause<br>od at the time, date a  | (s) and manner as s<br>and place, and due to | tated.<br>the cause(s)                             |
|                     | To the Hospital or Attend<br>within 24 hours after death<br>To the Funeral Director:<br>completely filled in by the  | Med              | 29b. Signature and title of cestifier   | and manner stated.   | 29c. License number  | 294  | Date signed (Month,                          | Day Year)  |
| )                   | 5 1 ₹ 5  |                  | 1 O Unlie   | MA   | OCME   |  |  |  |
|                     | 1  |                  | 30. Name and address of person who co   | impleted cause of death (Item 23a) (Ty)  |  | DEC  | EMBER 11,                                    | 2003   |
| 0                   |  |                  | TARON WK  | The state of death (nem 23a) (1y)  |  | ODE MARK                                       | T 13TD 01 =                                  | 0.1  |
|                     | Sta  | ate              | 31. Date filed (Month, Day, Year)   | 20 Di nietra de Cimpotrum  | PENN STREET, BALTIM  | UKE, MARY                                      | LAND, 212                                    | <del>)1</del>                                      |
| Ē.                  | Regist   | rar              | DEC 2 7 20  | 05 Section 19  | per  |  |  |  |

State Registrar DHMH 17 Rev 1/2001

| Please Type | or Print in | Black Indelible Ink. | <b>Ensure All Copies</b> | Are Legible |
|-------------|-------------|----------------------|--------------------------|-------------|
|             |             |                      |                          |             |

|  |                      | For State Registrar   | State of Ma   | aryland / [          |                              | artment of H   |  | Mental Hy   | /giene   | 005                 | 41716  |
|--|----------------------|---|---|----------------------|------------------------------|--|--|---|--|---------------------|--|
| Physici  | an                   | 1. Decedent's Name (First, Middle, Last)  |   | Le Nguyen            |                              |  | 2. Date of Death Month Day December 20, 2005 18:21 M       |   |  |                     |  |
| /Medio<br>Examin   |                      | 4a. Facility Name (If not institution, gir  | re street and number)   |                      |                              | 4b. City, Town, o  | r Location of Dea  |   | 4c. Co   | unty of Dea         | ath  |
| Funeral<br>Director  |                      | Greater Baltin<br>5. Social Security Number 6.2<br>231-87-6350  | 1 □ M 25F   |                      | rthday)<br>Yrs.              | Towson<br>If Under 1 Year<br>Months Days                                     | tf Under 24 Hr.<br>Hours Mir                               | 1. (Month, D  | rth  |                     | ore rthplace (State or Foreign ountry) ietnam                                  |
| D D  |                      | Usuat Residence of Decedent  10a. State 10b. County   |   | 10c. City, Tow       | m or Lo                      | cation   |  | Dec.  | 0,10,10  |                     | 10d. triside City Limits   |
| the Mar<br>r 28a-f st<br>notified  | Director             | Maryland Ba.  10e. Street and Number  | ltimore   |                      |                              | 10f. Zip Code  | Northw   | vood  | 10g. Citizer   | of What C           | 1 ☐ Yes 2 📉No  |
| be filed within 72 hours after death with the Maryland that Hygiene.  ed other than "naturel", or Items 23a or 28a-f show event, the Marical Examinational and the natified at   | Completed by Funeral | 6705 Queens Fer: 11. Maritat Status 1 Never Married 2 Married 3 Widowed 4 Divorced  | 12. Was Decedent Armed Forces? 1  | ?                    |                              | Was Decedent of H<br>f Yes, specify Cuba<br>1 ☐ Yes 2 ☑ No                   | 21239<br>ispanic Origin? (<br>an, Mexican, Pue<br>Specify: | Specify Yes or N<br>into Rican, etc.)   | 0- 14.   | Btack, Whi          | erican Indian,   |
| In y iding Z 12.200  |                      | 15. Decedent's E<br>(Specify only highest gr<br>Elementary/Secondary (0·12)   | College (1-4ors<br>2 Years  |                      | (Give<br>life.               | dent's Usual Occup<br>kind of work done<br>DO NOT use retired<br>Siness OW   | during most of wi<br>i)<br>ner/Mani                        |   | Man  | of Business         |  |
| be be eve  | To Be                | Trong Binh Ngu  | yen   | 100                  | . Namilia                    | 111 (64  | Ba No  | gac Le  |  |                     | Zin Code)  |
| Defailing of the permit Pages 1 and 2 should Department of Health and Mer Important: If item 27 is marke any injury or other traumatic once.   |                      | 19a. Informant's Name/Relationship  Mr. Thanh An r  20a. Method of Disposition  1 □ Burial 2 ☑ Cremation 3 (  '4 □ Donation 5 □ Other (Spec   | Truong<br>□Removal from State   | 20b. Place o cemete  | 5705<br>of Dispo             | ng Address (Street  Queens  sition (Name of natory or other place  Service C | Ferry Ro   | Date Bal  | timore<br>20c. Local   | , Mar               |  |
| berning Debards Debard |                      | 21. Signature of Funeral Service Lice 23a. Benti. Enter the disease, or cos shock, or heart failure. List off immediate Cause (Final disease or condition resulting in death)   | rplications that caused one cause on each li  | d the death. Do ine. | not ent                      | 2. Name and Addre<br>Ouda-Ruck<br>1922 Wise<br>er the mode of dyin           | ss of Facility<br>Funeral<br>Ave. I                        | l Home o:<br>Dundalk,   | Maryl  |                     | Inc.<br>21222<br>Approximate<br>Interval Between<br>Onset and Death<br>36 hour |
| ate be executed as system and the burial-transit   | dical Examiner       | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  | . Preuna  | a sunsequence        | d d                          | ntravaso<br>Deliver  |  | coagula   | tion   |                     | 36 hour<br>39 3/7 wee  |
| death certific   | Physician/Med        | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 □ No 9 □ Unknown  | 23c. If yes, outcome<br>1 St. ive birth<br>4 Pregnant a<br>9 Unknown                | 2 Fetal death        |                              | Ectopic pregnancy Other (specify)  | ,  |   |  | Date of de<br>Month | elivery Day Year 19,2005   |
| requires that the  | by                   | Part II. Other significant conditions   | ns contributing to death but not resulting in the underlying cause given in Part I. |                      |                              |  |  | 23e. Did tobacco use contribute to the cause of death?  1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown |  |                     |  |
| N > 0 0  | Completed            |   |   |                      |                              |  |  | auto<br>perf  | 24a. Was an autopsy findings avair prior to completion of cause death?  1☆ Yes 2 □ No 1 ☆ Yes 2 □ No |                     | completion of cause of   |
| ng Physician: Treatments of Physician: The this certification of the physician of the this certification.  | on: To Be            | 25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No  27. Manner of Death 1 ☑ Natural 5 ☐ Pending  | Hospital: 1 Inpati  | ury 28b.             | utpatier<br>Time o<br>Injury |  | er: 4 ☐ Nursing  | Home 5 Res  | idence 6 [   |                     | ecify)   |
| Hospitel or Attending Physician: The lave 24 hours atter death. Funerel Director: Atter this certificate has letely filled in by the funeral director, page 2.   | Certification:       | 2 Accident investigation 3 Suicide 6 Could not determine  | be 28e. Place of In   |                      |                              | M 1 □  | Yəs 2 □No  | 28f. Location<br>City or To   | (Street and Nown, State)   | lumber or F         | Rural Route Number,  |
| To the Hospite<br>within 24 hours<br>To the Funere<br>completely fille   | edical               | 29a. Certifier (Check only one)  13 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |   |                      |                              |  |  |   |  |                     |  |
|  | Σ                    | 29b. Signature and title of certifier   | 'AL   |                      | MC                           | 29c. Licens<br>D383  |  |   |  |                     | 21, 2005   |
| 10   |                      | 30. Name and address of person who eth R. Schwarts 31. Date filed (Month, Day, Year)  | z, M.D., 6  | 701 N.               | Cha                          | arles St   | .Balt.   | MD 212  | 04   |                     |  |
| Sta<br>Regist  |                      | DEC 2 7   | 2005  | we the               | 14                           | books  |  |   |  |                     |  |

Amend Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year 05 **Physician** Onlei 1047AM Edward 12 3 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** saltimore enter If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, 5. Social Security Number 6. Sex **Funeral** Days Year. 18 M 2□ F 8-20-2616 Yrs. MAR Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County or 28e-f show traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Director MARYLAND 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code or Items 23a by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after t Department of Health and Mental Hygiene. Important: if item 27 is marked other then "natural", or Iter may injury or other traumatic event, the Modical Exertine anse. 1 XYes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) HIGRADE 18. Mother's Name (First, Middle, Maiden Surname) (MN-UNKNOWN) 17. Father's Name (First, Middle, Last) Be NLEV ASEV HONEY Drive City or Town, State, Zip Code) 19b. Mailing Address (Street and Number or Rural 19a, Informant's Nam Pelationship (Type, Print) BALTO MD 21209 SON UATARUBA 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State METRO CREMATORY 12-26-05 SALTIMORE ^ 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address Facility BROWN JR, FUNERAL HOME 305 Ed N. FULTON AVE, BALTO. MD, 21217 21. Signature of Funeral Service Licensee Meams FULTON AVE. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final a Myocardial Physician 1 month disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Each of Uncertainty Cause (Disease or injury Due to (or as a consequence of) Examiner The law requires that the death certificate be executed use as the burial-transit that initiated events resulting in death) Last signed by the attending physician and a be detached for use as the burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? Month Day 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by aspiration PRELLIMOR 2 No 3 Probably 4 Unknown 1 🗌 Yes should 24b. Were autopsy findings available prior to completion of cause of death? 24a Wasan CHF ate has by page 2 s autopsy performed? res 20 No Yes 2 No 1 ☐ Yes 25. Was case referred to medical examiner?

1 Yes 2 No in by the tuneral director, Be 26. Place of Death (Check only one, Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27 Manner of Death Certification: After 1 Natural 2 Accident Injury 5 Pending 1 ☐ Yes 2 ☐ No death. investigation after death 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital or within 24 hours aft To the Funeral Di Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) completely 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier -1WD 16643 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) South Greene Street, Baltimore, mb 21201 MD les 31. Data filed (Month, Day, Year)
DEC 2 7 2005 32. Registrar's Signature State 7 2005 Brook 1 Registrar

|                |   | 1                | For   | partment of Health and Menta<br>Certificate of Death   | Hygiene<br>Reg. No. 005 41718  |
|----------------|---|------------------|---|--|--|
|                | Physicia  | an               | Decedent's Name (First, Middle, Last)   | 2. Date<br>Mod<br>DECEI  | e of Death<br>nth Day Year   |
|                | /Medic<br>Examin  | al -             | 4a. Facility Name (If not institution, give street and number)  | 4b. City, Town, or Location of Death   | 4c. County of Death  |
| la.            | Examin  |                  | Saint Joseph Medical Center   | Towson   | Baltimore  |
|                | Funeral<br>Director   |                  | 5. Social Security Number 6. Sex 1 M 2 F 7. Age (In yrs. last birthd  | Months Days Hours Min. (Mo   | e of Birth pith, Day, Year)  30/1914  9. Birthplace (State or Foreign Country)  MARY AND |
|                | ,<br>D  |                  | Usual Residence of Decedent  10a. State 10b. County 10c. City, Town o   | r Location   | 10d. Inside City Limits  |
|                | Maryli<br>Iled a  | tor              |   | TMORE  | 1 ☐ Yes 2 🗖 🗤 0  |
|                | or 28s  | Direc            | 10e. Street and Number  | 101. Zip Code 21234  | 10g. Citizen of What Country?  US A  |
|                | ns 23s  | Funeral Director | 8805 SPRING KD.  11. Marital Status  12. Was Decedent Ever in U.S.  | 13. Was Decedent of Hispanic Origin? (Specify Yell 14 Yes, specify Cuban, Mexican, Puerto Rican, 6 |  |
| 36             | filed within 72 hours after death with the Maryland<br>Hygiene.<br>ther then "natural", or items 23a or 28a-f show<br>out, it a Medical Evanirar must be notified at  | y Fur            | 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2,  No  | 1 Yes 22 No Specify:   | Specify:   |
| 215-0036       | 2 hours<br>atural',   | ted by           | 15. Decedent's Education 16a. De  | ecedent's Usual Occupation   | 16b. Kind of Business/Industry   |
| 215            | within 73<br>iene.<br>then "n   | Completed        | Elementary/Secondary (0-12) College (1-4or 5+)  | Sive kind of work done during most of working<br>fe. DO NOT use retired)<br>PERVISOR               | CANDY  |
| d 21           | filed w<br>Hygier<br>other th   | Be Col           | 17. Father's Name (First, Middle, Last)   |  | Middle, Maiden Surname)  |
| Maryland       | Mental Mental arked o   | To B             | GEORGE GEIWITZ  |  | 74 LINDENBACH  |
| Mar            | id 2 sho<br>Ith and<br>27 is mu<br>traum  |                  |   | lailing Address (Street and Number or Rural Route  | ACTIMORE MO 21234  |
| ore,           | nit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan artment of Health and Mental Hygiene. ortant: if item 27 is marked other than "natural; or items 23a or 28a-1 show injury or other traumatic event, it a Medical Examinat must be notified at injury or other traumatic event, it a Medical Examinat must be notified at a. |                  | 20b. Place of D   | isposition (Name of crematory or other place)  December  | 20c. Location - City or Town, State  |
| Baltimore,     | permit. Page<br>Department o<br>important: if<br>eny injury or<br>once.   |                  | 4 Donation 5 Other (Specify)  | NE PARK 29, 200°<br>22. Name and Address of Facility EVANS   |  |
| Ba             | Depa<br>Impo<br>eny is  |                  | Kith Sla  | 8800 HARFORD RD  | . Arkville, mo 21234   |
|                |   |                  | 23a. Part1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line.  | enter the mode of dying, such as cardiac or respir   | ratory arrest, Approximate Interval Between Onset and Death                              |
|                | Physician<br>/Medical   |                  | Immediate Cause (Final disease or condition resulting in death)  a.   ACUTE MYDCARD:  Due to (or as a consequence of)   |  |  |
| i de           | Examiner  |                  | Sequentially list conditions b  |  |  |
| A/             | uted<br>d<br>ansit  | Examiner         | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury   |  |  |
| ,092           | be executed<br>icien and<br>burial-transit  |                  |   |  |  |
| 6876           | ficate b<br>physic<br>s the b   | edical           |   |  |  |
| Box (          | eath certificate be executed<br>attending physicien and<br>for use as the burial-transit  | an/M             | IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death  | 3 ☐Ectopic pregnancy   | 23d. Date of delivery  Month Day Year  |
| P.O. E         | 0 0   | ysici            | in the past 12 months?  1  Yes 2 No 9 Unknown  4 Pregnant at time of death 9 Unknown  | 5 Other (specify)  |  |
|                | requires that the<br>een signed by th<br>nould be detache   | by Physician/Med | Part II. Other significant conditions contributing to death but not resulting in the  | ne underlying cause given in Part I. 23  | Be. Did tobacco use contribute to the cause of death?                                    |
| Vital Records, |   | eted             |   | 24   | 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown  Ia. Was an 24b. Were autopsy findings available |
| Rec            | e lav<br>has<br>je 2  | Completed        |   |  | autopsy performed? performed? death? 1 □ Yes 2 No 1 □ Yes 2 No                           |
| /ital          | yeician: Th<br>is certificate<br>director, pag  | Be               | 25. Was case referred to medical examiner?  | 26. Place of Death (Chec   | ck only one)   |
| of             | Phyer this ral dil  | n: To            | 1 Yes 200 No 1 Incline 2 EP/Outp  | ne of 28c. Injury at 28d. De   | Residence 6 Other (Specify)  |
| Division       | Attending F r death. ector: After by the funera   | catio            | 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be   | M 1 Yes 2 No   |  |
| Divis          | or Attendation after death  | Certification:   | 4 Homicide  4 Homicide  4 Homicide  4 See Place of Injury - At home, farm building, etc. (Specify)  |  | cation (Street and Number or Rural Route Number,<br>ty or Town, State)                   |
|                | To the Hospital or At within 24 hours after or To the Funeral Direct completely filled in by  | edical C         | 29a. Certifier (Check orly one)  Certifying Physician: To the best of my knowledge, one)  Certifying Physician: To the best of my knowledge, one one one of the basis of examination and/one one one one one of the basis of examination and/one one one one of the basis of examination and/one one one of the basis of examination and manner stated. |  |  |
|                | To the within To the comple   | Me               | 29b. Signature and title of certifier   | 29c. License number  | 29d. Date signed (Month, Day, Year)  |
|                |   |                  | January   | D 30263  | 12-24-05   |
|                | 5   |                  | 30. Name and address of person who completed cause of death (Item 23a) (T   | ype, Print)<br>R. DRIVE TOWSON. MAR  | YLAND 21204  |
| To the second  | St<br>Regist  | ate<br>rar       | 31. Date filed (Month, Day, Year) DEC 2 7 2005  32/Registrar's Signature  | 4  |  |

|                  |   |                           | 1 - For<br>State<br>Registrar   | State of Maryla   |                         | artment of I<br>rtificate of           |                      | Mental Hy                   | /giene           | 05                                      | +   7                            | 9                    |
|------------------|---|---------------------------|---|---|-------------------------|--|----------------------|-----------------------------|------------------|---|----------------------------------|----------------------|
|                  |   |                           | 1. Decedent's Name (First, Middle, Las  | t)  |                         |  |                      | 2. Date of D                | eath<br>Day      | Year                                    | 3. Time of                       | Death                |
|                  | Physici<br>/Medic   |                           | MADELINE M.   | OFFLEY  |                         |  |                      | DECEMB                      |                  | 2005                                    | 1:28                             | PM                   |
|                  | Examin  |                           | 4a. Facility Name (If not institution, give   | street and number)                                      |                         | 4b. City, Town,                        | or Location of Death | 1                           | 4c. Coi          | unty of Death                           |                                  |                      |
|                  |   |                           | JOHNS HOPKINS C   | MRE CENTER  |                         | BAUTIM                                 |                      |                             |                  |   |                                  |                      |
|                  | Funeral   |                           | Social Security Number     6. Security Number   | 7. Age (In yrs  |                         | If Under 1 Year<br>Months Days         |                      | 8. Date of Bi               | rth<br>ay, Year) | Cour                                    | olace (State o                   | r Foreign            |
|                  | Director  |                           | 215-10-4057   |   | 93 Yrs.                 |  |                      | May 2                       | 3, 1912          | 4                                       | MD                               |                      |
|                  | and   |                           | Usual Residence of Decedent  10a. State 10b. County   | 10c. C  | ity, Town or Lo         | cation                                 |                      |                             |                  | 1                                       | 0d. Inside Ci                    | ty Limits            |
|                  | Aaryl.  | ō                         | M) 2.11   | 4:00.00   | 2                       | . 6/2 11                               |                      |                             |                  |   | 1 🗋 Yes                          | 200 No               |
|                  | 28a-  | Director                  | 10e. Street and Number  | inace   | 1 CRE                   | 10f, Zip Code                          |                      |                             | 10g. Citizen     | of What Cour                            | ntry?                            |                      |
|                  | with<br>Ba or   | 0                         | 9715 Ban  | 1 / 200.00  | 11                      | 2                                      | 1218                 |                             |                  | USA                                     |                                  |                      |
|                  | ms 2;   | by Funeral                | 11. Marital Status  | 12. Was Decedent Ever in                                | J.S. 13.                | Was Decedent of                        | Hispanic Origin? (S  | pecify Yes or N             |                  | Race - Americ                           |                                  |                      |
| က                | or ite  | Ē                         | 1 Never Married 2 Married   | Armed Forces?<br>1 ☐ Yes 2 ☐ No                         |                         |  | oan, Mexican, Puert  | o Hican, etc.)              |                  | Black, White,                           | ,                                |                      |
| ğ                | ral', c   | l by                      | 3 ₩idowed 4 Divorced  | If Yes, Give<br>Year or Dates:                          |                         | 1□Yes 2᠒ No                            | Specify:             |                             | Spi              | ecity: WK                               | 110                              | _                    |
| 21215-0036       | filed within 72 hours after death with the Maryland<br>Hygiene.<br>yther than "natural", or items 23a or 28e-f show<br>yth, the Medical Evanting must be rudified at  | Completed                 | 15. Decedent's Ed<br>(Specify only highest gra  | lucation<br>de completed)                               | (Give                   | dent's Usual Occu<br>kind of work done | during most of wor   | king                        | 16b. Kind o      | of Business/In                          | dustry                           |                      |
| 2                | ithin san *   | μ                         | Elementary/Secondary (0-12)   | College (1-4or 5+)                                      | life.                   | DO NOT use retire                      | ed)                  |                             | (,)              | SKRNI                                   | E/- 1                            |                      |
|                  | filed with<br>Hygiene.<br>other than  |                           | 12  |   | 1-6                     | retory                                 | 18. Mother's Nam     | DIER                        |                  |   | Lieer                            | RIC                  |
| P                | be fil<br>Ital H<br>Id ott  | Be                        | 17. Father's Name (First, Middle, Last)   |   |                         | •                                      | 18. Mother's Nam     | ne (First, Middle           | e, Maiden Sur    | name)                                   |                                  |                      |
| 3                | ould be<br>I Mental<br>narked c   | 1º                        | Clarence J  | ollett  | 405 14-20               |  | Cora                 | - //LOK                     | 2R15             |   | 0.4-1                            |                      |
| Maryland         | nit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan artiment of Health and Mental Hygiene. ortant: if item 27 is marked other than "natural", or items 23s or 28s-f show injury or other traumatic event, the Medical Examinat must be retified at 8. |                           | 19a. Informant's Name/Relationship (7   | 17  | 19b. Mailir             | ng Address (Stree                      | t and Number or Ru   | rai Houte Numi              | L City or 10     | wn, State, Zip                          | (AU) A                           | 12.6                 |
|                  | t and<br>Health<br>em 27  |                           | 20a. Method of Disposition  | 1cy - SON   | Place of Dispo          | sition (Name of                        | RNORD Z              | Date                        | 20c. Locati      | ion - City or To                        | own. State                       | 1410                 |
| ٥                | Pages<br>nent of I<br>int: if it  |                           | 1 Burial 2 □ Cremation 3 □  | Removal from State                                      | cemetery, crer          | natory or other pla                    | 1Ce)                 | 1 1                         | 6                | , ,                                     | 200                              |                      |
| Baltimore,       | t. Partmer<br>rtmer<br>rtant<br>njury   |                           | <ul> <li>4 □ Donation 5 □ Other (Specify</li> <li>21. Signature) of Funeral Service Lies</li> </ul> | n VII(e   | adowna                  | JE Mem.                                | Park 12              | 128/05                      | EIK              | Ridge                                   | , mi                             | 2                    |
| Bal              | permit. Page<br>Department o<br>Important: If<br>any injury or<br>once.   |                           | 21. Signature of Funeral  | - 110111-   | _                       | Bradi                                  | 14- Ashi             | ton Fu                      | Neral            | Nom                                     | e, P.K                           | 1.                   |
|                  |   |                           | 23a. Part1. Enter the disease, or comp  | plications that caused the dea                          | ith. Do not ent         | er the mode of dvi                     | ing such as cardiag  | or respiratory              | INS A            | CQ. 2                                   | Approximate                      | <b>-</b>             |
| H                |   |                           | shock, or heart failure. List only<br>Immediate Cause (Final  | one cause on each line.                                 |                         |  |                      | , , , , ,                   |                  |   | Interval Bet<br>Onset and I      |                      |
|                  | Priysician<br>/Medical  |                           | disease or condition resulting in death)  | a. DEMENTIA   |                         |  |                      |                             |                  | -                                       | + YEAH                           | 25                   |
|                  | Examiner  |                           | ſ   | Due to (or as a conse                                   | quence on:              |  |                      |                             |                  |   |                                  |                      |
|                  |   | ē                         | Sequentially list conditions, if any, leading to immediate  | b. Due to (or as a conse                                | quence of):             |  |                      |                             |                  |   |                                  |                      |
|                  | uted<br>d<br>ansit  | Examiner                  | cause. Enter Underlying<br>Cause (Lisuase or injury<br>that initiated events                        | C   |                         |  |                      |                             |                  |   |                                  |                      |
| ó                | exec<br>an an<br>rial-tr  |                           | resulting in death) Last  | Due to (or as a conse                                   | quence of):             |  |                      |                             |                  |   |                                  |                      |
| 8760             | tate be executed by sician and the burial-transit   | dical                     |   | . d   |                         |  |                      |                             |                  |   |                                  |                      |
| 9                | death certificate be executed<br>e attending physician and<br>nd for use as the burial-transit  | Ned                       | IF FEMALE.  |   |                         |  |                      |                             |                  |   |                                  |                      |
| Box              | leath certific<br>attending p   | an/N                      | IF FEMALE:<br>23b. Was decedent pregnant  | 23c. If yes, outcome of pregr<br>1 ☐ Live birth 2 ☐ Fet |                         | Ectopic pregnanc                       | cy .                 |                             | 23d.             | Date of delive<br>Month                 |                                  | r'ear                |
|                  | edea<br>he att  | sicia                     | in the past 12 months?<br>1 □ Yes 2 5 No  | 4☐Pregnant at time of<br>9☐Unknown                      |                         | Other (specify)                        |                      |                             |                  | MOTITI                                  | Day Y                            | 841                  |
| P.O.             | at the  | Phy                       | 9 Unknown   |   |                         |  |                      | 00 - Did                    |                  |   |                                  |                      |
|                  | w requires that the debean signed by the should be detached   | b                         | Part II. Other significant conditions of  |   |                         |  | iven in Part I.      | _                           |                  | contribute to th                        |                                  |                      |
| ord              | equii<br>sen s  | ted                       | ATRIKE PIBRILLY II  |   | EN510                   | 100                                    |                      | ''                          | Yes 2 N          | 0 3 T F100                              | oably 4 □U                       | ITIKTIOWIT           |
| ec               | 2 5   | pie                       | CEREBROVASCUL   | M DISEASE   |                         |  |                      | 24a. Wa<br>auto             | psy              | 4b. Were auto<br>prior to co            | psy findings a<br>mpletion of ca | available<br>ause of |
| <u> </u>         | ate pa  | Completed by Physician/Me |   |   |                         |  |                      | perī<br>1 ☐ Yes             | ormed?<br>2€ No  | death?<br>1 ☐ Yes                       | 2X No                            |                      |
| of Vital Records | Phyaician: Th<br>r this certificate<br>ral director, pag  | Be                        | 25. Was case referred to medical examiner?  |   |                         |  | 26. Place of Dea     | ith (Check only             | one)             |   |                                  |                      |
| <u>\</u>         | hyai<br>his c   | 은                         | 1 Yes 2 No  |   | ER/Outpatier            | it 3 DOA                               |                      | ome 5 Res                   |                  |   | y)                               |                      |
|                  | ing P   | on;                       | 27. Manner of Death  1. Natural 5 Pending   | 28a. Date of Injury<br>(Month, Day Year)                | 28b. Time of<br>Injury  | Wo                                     |                      | 28d. Describe               | how injury of    | curred                                  |                                  |                      |
| sio              | Attending<br>ir death.<br>ector: After<br>by the fune   | cati                      | 2 Accident investigation 3 Suicide 6 Could not be   |   |                         |  | ]Yes 2 □No           | 004  +                      | (Charan and A)   |   | / D 1/                           | h                    |
| Division         | or Attendate death I Director: /  | Certification;            | 4 Homicide determined   | 28e. Place of Injury - At I<br>building, etc. (Spec     | nome, rarm, str<br>ify) | eet, factory, office                   |                      | 28f. Location<br>City or To | own, State)      | umber or Hura                           | u Houte Num                      | Der,                 |
| ш                | Hospital 4 hours a Funeral I tely filled  |                           | 29a. Certifier 15 Certifying Ph   | ysician: To the best of my kr                           | owlodgo, doot           | h convered at the                      | ime date and place   | and due to the              |                  |   | tatad                            |                      |
|                  |   | edicai                    |   | niner: On the basis of examinand manner stated.         | ation and/or in         | vestigation, in my                     | opinion, death occu  | rred at the time            | , date and pla   | ce, and due to                          | the cause(s                      | }                    |
|                  | o the<br>o the<br>omple   | Me                        | 29b. Signature and title of certifier   |   |                         | 29c. Licen                             | ise number           |                             | 29d. Date si     | gned (Month,                            | Day, Year)                       |                      |
|                  | FSFO  |                           | 1 2 / 1/-   | mali NIN  |                         | 7000                                   | 62032                |                             | DECEM            | ser 26                                  | 200                              | 5                    |
| 1                | -1  |                           | 30. Name and address of person who  | completed cause of death (Ite                           | m 23a) (Type.           |  | 2007                 |                             | 1/CLOWN          | ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, | ,                                |                      |
| 10               |   |                           |   |   |                         | TIMORE                                 | MD 2                 | 1224                        |                  |   |                                  |                      |
|                  | Sta   | ite                       | 31. Date filed (Month, Day, Year)   | 32. Registrar's Sign                                    | nature                  | ,                                      |                      | (                           |                  |   |                                  |                      |
| ŀ                | Regist  | rar                       | DEC 2 7 2005  | Berene J.   | SALVE SEL               |  |                      |                             |                  |   |                                  |                      |

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** December 18, 2005 11:20 AMM Barbara Olgeirson /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Manor Care Ruxton Baltimore If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Yeer) Birthplece (State or Foreign Country) **Funeral** 1 □ M 2 🕁 F Director 103-16-5041 87 Sept 14, 1918 Phillipines Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location iral', or Items 23a or 28e-f show Examiner must be notified at 1 ☐ Yes 2 🔽 No Director Baltimore Baltimore the 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number death with USA 21234 8800 Old Harford Road #217 by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: white 1 ☐ Yes 2 ☑ No Specify If Yes, Give Year or Dates: 3 ₩ Widowed 4 Divorced natural Completed er than 'natur'. The Medical J 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) and Mental Hygiene. education 12 teacher 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Annie Eliza Ensley Maurice Dlaisted Alger 은 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important: If Item 27 Is any injury or other treu 5705 St. Albans Way Baltimore, MD John Olgeirson/son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stete 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State \* 4 X Donation 5 ☐ Other (Specify) 21. Signature a Funeral Pervice Licensee Ronald S. J. State Anatomy Board 655 W. Baltimore Street mark Baltimore, MD 21201 23a. Panj. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, show, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) EREBROVASCULAR THROMBOSIS **Physician** /Medical Due to (or as a consequence of) Weeks. Examiner 180 De Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examine To the Hospitel or Attending Physicien: The law requires that the death certificate be executed burial-trar Due to (or as a consequence of): attending physician for use as the burial Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Day Year 4☐ Pregnant at time of death 5 Other (specify) P.O. the 9 Unknown Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a Wasan page 2 s autopsy performed? res 2 No certificate 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 Inpatient 2 ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 😿 No 3 DOA Certification; To this 28c. Injury at Work? 28a. Date of Injury (Month, Day Yeer) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After Injury Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 154 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29b. Signature and 146 of certifier 0-0012849 lach m 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) OSLER Dr TOWSON MD 21204 GHILADI. 2. Registrar's Signature 31. Date filed (Month, Day, Year) State 7 2005 Registrar

|                        | 1- State of Maryland / Department of He Registrar  State of Maryland / Department of He Certificate of D   |   |  | giene<br>Reg. No. 0                 | 5                                   | 41721   |
|------------------------|--|---|--|-------------------------------------|-------------------------------------|---|
| ciaion                 | Decedent's Name (First, Middle, Last)  |   | 2. Date of Dea                           | ath                                 |                                     | 3. Time of Death                                |
| /sician<br>ledical     | Nancy Jean Petrarca  |   | Decembe                                  | er 24,20                            | 0 <b>05</b> °                       | 8:30 P. M                                       |
| aminer                 | 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or L  | Location of Death                                     |  | 4c. County                          | of Death                            |   |
| € <sup>3</sup> , °     | 827 W. Padonia Road Timot  5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year   | nium<br>If Under 24 Hrs.                              |  |                                     |                                     | County  |
| eral<br>tor            | 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year 20-66-7156 50 Yrs. Months Days   | Hours Min.  | 8. Date of Birt<br>(Month, Day<br>July 2 | h<br>7 1955                         | 9. Birthp                           | place (State or Foreign<br>ntry)<br>LLMOTE, VID |
|                        | Usual Residence of Decedent  |   | July 2                                   | ,1900                               | Dail                                | THOLE, ND                                       |
|                        | 10a. State 10b. County 10c. City, Town or Location   |   |  |                                     | 1                                   | 10d. Inside City Limits                         |
| Director               | Maryland Baltimore County Timonium   |   |  |                                     |                                     | 1 ☐ Yes 2 ₹ No                                  |
| Dire                   | 10e. Street and Number 10f. Zip Code   |   |  | 10g. Citizen of                     | What Cour                           | ntry?   |
| E E                    |  | 030   |  | United                              | l Sta                               | tes   |
| by Funeral             | 11. Marital Status  1 □ Never Married 2 □ Married  1 □ Never Married 2 □ Married  3 □ Widowed 4 ☑ Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 □ Ves 2 □ No  If Yes, Give Year or Dates:  13. Was Decedent tof Hisp If Yes, specify Cuban.   | spanic Origin? (Spe<br>n, Mexican, Puerto<br>Specify: | ecify Yes or No-<br>Rican, etc.)         |                                     | ce - Americ<br>ck, White,<br>y: Whi |   |
| Completed              | 15. Decedent's Education 16a. Decedent's Usual Occupation  | tion  |  | 16b. Kind of B                      | usiness/In                          | dustry  |
| pje                    | (Specify only highest grade completed)  (Give kind of work done du life. DO NOT use retired)  Elementary/Secondary (0-12)  College (1-4or 5+)  | urina most of workii                                  | ng                                       |                                     |                                     | ,   |
| Con                    | 12 03 Self Empl  | loyed   |  | Real Es                             | state                               | Developer                                       |
| Be                     |  | 18. Mother's Name                                     |  |                                     |                                     |   |
| To.                    |  | May Eliza   |  |                                     |                                     |   |
| 1                      | 19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and   |   |  |                                     |                                     |   |
|                        | John E. Adams, M.D. (Companion) 827 W. Padonia  20a. Method of Disposition (Name of  |   | moniun,                                  |                                     |                                     | 21030   |
| 1                      | 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place)  | }   | ate                                      | 20c. Location -                     | -                                   |   |
| 3                      | 4 Donation 5 Other (Specify) Evans Funeral Chape 21. Signature of Funeral Service Liceusee   |   | 2  |                                     |                                     |   |
|                        | 21. Signature of Fun ral Service Lice See  22. Nam - Ind Ad 3 - F  23. P 1. Enter the diserse, or compliciting that caused the death. Do not enter the mode of dying,  | bad Timo  | s Funer<br>nium,Ma                       | al&Crei<br>ryland                   | oti<br>210                          | g_Ctr.,P.A                                      |
| dicai Examiner         | Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, frain, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of): |   |  |                                     |                                     | Onset and Death                                 |
| Physician/Me           | IF FEMALE:  23b. Was decedent pregnant in the past 12 shorths?  1  Yes 2 No 9 Unknow    23c. If yes, outcome of pregnancy  1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown 5 Other (specify)  |   |  | 23d. Dat<br>Mor                     | e of delive                         | ry<br>Day Year                                  |
| ۵                      | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given  | in Part I.  | 23e. Did tol                             |                                     | ibute to the                        | e cause of death?                               |
| Completed              |  |   | 24a. Was a autops perform                | y p                                 | Vere autop<br>rior to com<br>leath? | osy findings available inpletion of cause of    |
| ပို                    | 25. Was case referred to medical   |   | 1 ☐ Yes 2                                | No 1                                | Yes                                 | 2 No  |
| o B                    | examiner? Hospital:  | 26. Place of Death                                    |  |                                     | -                                   |   |
| I                      | 27. Manger of Death 28a. Date of Injury 28b. Time of 28c. Injury at  | 4   Nursing Hom                                       | 8d. Describe ho                          |                                     |                                     | )   |
| atio                   |  | s 2 No  |  |                                     |                                     |   |
| Certification:         | 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   | 21  | 8f. Location (St.<br>City or Town        | reet and Number, State)             | er or Rural                         | Route Number,                                   |
| edical (               | 29a. Certifier (Chock only one)  Certifying Physician: To the best of my knowledge, death occurred at the time, 2 Medical Examiner. On the basis of examination and/or investigation, in my opinion and manner stated.   | , date and place, ar<br>non, death occurre            | nd due to the ca<br>d at the time, da    | iuse(s) and mai<br>ate and place, a | nner as sta<br>nd due to            | atedthe cause(s)                                |
| Medical Certification; |  | number  | 25                                       | d. Date signed                      | (Month, D                           | Day, Year)                                      |
| 1 "                    | DS8  | 3303  |  | Decem                               | ber .                               | 260 2005  |
| 0                      | 29b. Signature and attended to certifier  29c. License n  D 5 8  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  51. Date filed (Month, Day, Year)  32. Registrar's Signature  | it Bon  | Dan -                                    | (1.00)                              | 7 11 8                              | 7 L   |
| State                  | 31. Date filed (Month, Day, Year) 32. Registrar's Signature  |   | OLF VVIV                                 | 7013                                | UU                                  | 7   |
| istrar                 | DEC 2 7 2005 Revenue & Sparke  |   |  |                                     |                                     |   |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 2005 04:45A M December /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner PERRY POINT

If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. CECIL VA MARYLAND HEALTH CARE SYSTEM 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign 6. Sex 1 M 2 □ F **Funeral** Country) Director Usual Residence of Decedent death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours atter death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "naturat", or Items 23s or 28a-1 show any nightry or other traumatic event, the Medical Examiner must be notified at once. 10a. State 1 Yes 2 No NAME KNOWN TO PHYSICIAN: PETE PROPALIS Baltimore, Maryland 21215-0036 SALTIMORE Funeral Director TIMO 10g. Citizen of Wha! Country? 10f. Zip Code 10e. Street and Number 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 DYes 2 □ No Iff Ns, Give Year or Dates: 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Specify: White 1 ☐ Yes 2 No Specify: þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT yee retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Midgle, Last) Be a Pb. Mailing Address (Street and Numberfor Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition cemetery, crematory or other place. 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) 30/05. 22. Name and Address of Facility BALTIMORE, MD 21. Signature of Funeral Service Licensee EVANS FUNERAL CHAPEL 8800 HARFORD 23a. Pahri. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one gause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final UNKNOWN **Physician** PROSTATE CANCER WITH METASTASIS disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulling in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed cate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year Day 5 Other (specify) ☐Yes 2☐No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 Probably 4 Munknown 1 ☐ Yes 2 ☐ No. Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 ♣No certificate has 1 Yes 2 No Hospitat or Attending Physicien: 4 hours after death. Funeral Director: After this certifice the funeral director, 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Other: 4 Nursing Home 5 Residence 6 Olher (Specify) 1 ☐ Yes 2 X No 1X Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 1 Natural 28a. Dale of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Certification: Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 | Homicide To the Hospitat within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the lime, date and place, and due to the cause(s) 29a. Certifier Medical (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 21164 Jiana. DECEMBER 25, 2005 VA 01010580281 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ., VA MARYLAND HEALTH CARE SYSTEM, PERRY POINT, MD 2002 JIANYI ZHANG, M.D. State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend item#5, periff (351, 1,6/06 TI State of Maryland / Department of Health and Mental Hygiene) 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** MARGARET IRENE PATRICK DECEMBER 22, 2005 4:45 P. M. /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death FOREST HILL HEALTH & REHAB CENTER FOREST HILL HARFORD 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral 1 □ M **2**X□ F Days 183-18-8338<sup>917</sup> 85 Hours Yrs. Director Oct. 4, 1920 Virginia with the Maryland 10a. State 10b. County 7 is markad other than "natural", or Itams 23a or 28a-f show traumatic avent, the Medical Examinar must be notified at 10c. City, Town or Location 10d. Inside City Limits Maryland Harford Directo Bel Air 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death v Funeral 2018 A Ruffs Mill Rd. 21015 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Y Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black. White, etc. filed within 72 hours after 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🙀 No Completed by Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Il Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Administrative Assistant U.S. Government 17. Father's Name (First, Middle, Last) rmit. Pages 1 and 2 should be file spartment of Health and Mental Hi portant: If itam 27 is markad oth y injury or other traumatic aven 18. Mother's Name (First, Middle, Maiden Sumame) Be Eugene (nmn) Testerman Minnie Mae 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Hazel V. Osborne -Sister 2018 Ruffs Mill Road, Bel Air, Maryland 21015 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or once. \* 4 ☐ Donation 5 ☐ Other (Specify) Dublin Southern Cem. 12/27/05 Darlington, Maryland 21. Signature of Juneral Service Licenses 22. Name and Address of Facility McComas Funeral Home, P.A. 50 West Broadway Street, Bel Air, MD 21014 23a. Part1. Enter the disease, or complications that shock, or heart failure. List only one cause on caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) 1ears /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 Probably 4 □Unknown Completed certificate has b irector, page 2 s 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 766 autopsy performed 1 ☐ Yes 2 No To the Hospital or Attanding Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 € No 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending Director: / 2 Accident investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Thomicide within 24 hours a To tha Funaral D 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed (Month, Day, Year)
DEC 2 7 2005

DR. MANUEL LAZATIN

30. Name and address of person who completed cause of

8 LAW STREET —
Registrar's Signature

death (Item 23a) (Type, Print)

ABERDEEN, MD.

21001

|           |  |                | 1 - For<br>State<br>Registrar  | State of Ma   | aryland      |                              | artmer<br>rtificat                   |                            |  | nd Me      |                              | giene<br>Reg. No         | UUU                         |                    | 1725   |
|-----------|--|----------------|--|---|--------------|------------------------------|--------------------------------------|----------------------------|--|------------|------------------------------|--------------------------|-----------------------------|--------------------|--|
|           | Physici  | an             | Decedent's Name (First, Middle,  | Last)   | _            |                              |                                      |                            |  |            | 2. Date of De<br>Month       | aath<br>21 <sup>Da</sup> | y 2005°                     | ar                 | 3. Time of Death                             |
|           | /Medic   | al             | Jessie   | and and an about  | Lee          |                              |                                      | well                       | 1  | D          | 12                           |                          |                             |                    | 10:15a M                                     |
|           | Examin   | er             | 4a. Facility Name (If not institution, g<br>5638 Harbor V  |   | 2            |                              | 4b. City,                            |                            | Location of  |            |                              | 40                       | . County of [               | )eath              |  |
| L.        | Funeral  |                |  |   |              | ast birthday)                |                                      | r 1 Year                   | If Under 24  | 4 Hrs.     | B. Date of Bir<br>(Month, Da | th                       | 9.                          | Birthpl            | ace (State or Foreign                        |
|           | Director   |                | 245-72-1186  | 1□M 2XF   | 51           | Yrs.                         | Months                               | Days                       | Hours  | Min.       | 02-2                         | 3–44<br>3–44             |                             | Count              | N.C.   |
|           | pui  |                | Usual Residence of Decedent  10a. State 10b. County  |   | 10c City     | , Town or Lo                 | nation                               |                            |  |            |                              |                          |                             | -                  |  |
|           | Aanyle<br>I sho  | ŏ              |  |   | Toc. Ony     |                              |                                      |                            |  |            |                              |                          |                             | 10                 | Od. Inside City Limits Yas 2 No              |
|           | 28a-1  | Director       | Md. 1  | IA  |              | Bal                          | Ltimo                                |                            |  |            |                              | 10a Ci                   | tizen of Wha                | t Count            |  |
|           | 3a or  |                |  | uldin Stree   | t            |                              |                                      |                            | 21205  |            |                              |                          | USA                         | Coun               | u y :  |
|           | d within 72 hours after death with the Maryland<br>piene.<br>I then "naturel", or Items 23a or 28a-f show<br>Item Medical Examiner must be coulified at  | Funerai        | 11. Marital Status   | 12. Was Decedent  | Ever in U.S  | 5. 13.                       | Was Dece                             | dent of Hi                 | spanic Origin  | n? (Spec   | ify Yes or No<br>ican, etc.) |                          | 14. Race - /                |                    |  |
| 0         | after<br>or its  | / Fu           | 1 ☐ Never Married 2 ☐ Married  | Armed Forces? 1 ☐ Yes 2 🔼 N                                   | No           |                              | n Yes, spe<br>1 ☐ Yes                |                            |  | Pueno R    | ican, etc.)                  |                          | Black, V                    |                    |  |
| 0-000c    | ural',   | d by           | 3 Widowed 4 Divorced   | If Yes, Give<br>Year or Dates:                                |              |                              |                                      |                            |  |            |                              |                          | Specify:                    | B1a                |  |
|           | n 72<br>n nat  | Completed      | 15. Decedent's<br>(Specify only highest  | grade completed)  |              | 16a. Dece<br>(Give           | dent's Usu<br>kind of wo<br>DO NOT u | rk done d                  | lurina most o  | of working | 7                            |                          | ind of Busin<br>timore      |                    |  |
| 7         | within iene.   | ша             | Elementary/Secondary (0-12)  | College (1-4or 5<br>N/A                                       | i+)          |                              | Prof                                 |                            |  |            |                              |                          | blic S                      |                    | -  |
| 2         | Hygent, ant,   | Be C           | 12th grade<br>17. Father's Name (First, Middle, La   | st)   |              |                              |                                      |                            | 18. Mother's   | s Name (   | First, Middle                |                          |                             |                    |  |
| land      | 0 0 0 0 0  | To B           | Eugene Leak  |   | ,            |                              |                                      |                            | Ann  | nie U      | Inderh:                      | i11                      |                             |                    |  |
| Mar       | s 1 and 2 should be<br>t Health and Menta<br>Itsm 27 ie marked<br>other traumatic sv   |                | 19a. Informant's Name/Relationship   | (Type, Print)   |              | 19b. Maili                   | ng Address                           | s (Street a                | and Number   | or Rural   | Route Numb                   | er, City                 | or Town, Sta                | te, Zip            | Code)  |
| ≥<br>15   | 5 = 2 5  |                | Joseph Powell,   | Sr - Husb   |              |                              |                                      |                            | Street   |            | lto, N                       |                          |                             |                    |  |
| 0         | Pages 1 and the pages 1 and th |                | 20a. Method of Disposition 1 X Burial 2 □ Cremation 3  | Removal from State  | CB           | metery, crei                 | matory or o                          | other plac                 | 9)   | Da         |                              |                          | ocation - City              |                    |  |
| апппог    | it. Pa   |                | 4 □ Donation 5 □ Other (Spe<br>21. Signature of Funeral Service Lig  |   | KIII         | g Mem                        |                                      |                            | 1  | . 2-20     | 3-2005                       |                          |                             |                    |  |
| ā         | permit. Pages<br>Department of<br>Important: If II<br>any Injury or once.  |                | Mul  | C. Shu  | Mtl          | 24                           |                                      |                            | s of Facility  I. Wes  | t ·        | Balti<br>4300 W              | more<br>Jabas            | e, Md.<br>sh Ave            |                    | 1215   |
|           | Physician  |                | 234. Part Enter the disease, or or shock, or heart failure. List or<br>Immediate Cause (Final disease or condition resulting in death) | emplications that caused<br>by one cause on each lin          | ne.          |                              | Cin C                                |                            | g, such as ca  | ardiac or  | respiratory a                | rrest,                   |                             | _                  | Approximate Interval Between Onset and Death |
|           | /Medical<br>Examiner   |                | resulting in death)  | Due to (or as   | a consequ    | ence of):                    |                                      |                            |  |            |                              |                          |                             |                    |  |
|           |  | 9              | Sequentially list conditions,  | b. Due to (or as  | a consequ    | ence of):                    |                                      |                            |  |            |                              |                          |                             |                    |  |
|           | ate be executed hysicien and the burial-transit  | Examiner       | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events      |   |              | ,                            |                                      |                            |  |            |                              |                          |                             |                    |  |
| o Î       | exec<br>en an<br>rial-tr   |                | resulting in death) Last   | Due to (or as   | a consequ    | ence of):                    |                                      |                            |  |            |                              |                          |                             |                    |  |
| 2/07      | certificate be executed<br>Iding physicien and<br>Ise as the burial-transit  | ical           |  | d   |              |                              |                                      |                            |  |            |                              |                          |                             |                    |  |
| õ         | artifica<br>ing ph<br>e as ti  |                | IF FEMALE:   |   |              |                              |                                      |                            |  |            |                              |                          |                             |                    |  |
| X<br>D    | w requires that the death certific:<br>been signed by the attending pl<br>should be detached for use as t  | Physician/Mec  | 23b. Was decedent pregnant in the past 12 months?  | 23c. If yes, outcome<br>1☐Live birth                          | 2 Fetal      | déath 3[                     | Ectopic p                            |                            |  |            |                              |                          | 23d. Date of<br>Month       |                    | y<br>Day Year                                |
|           | he de<br>r the a   | ysic           | 1 ☐ Yes 2 ☐ No<br>9 ☐ Unknown  | 4□Pregnant at<br>9□ Unknown                                   | time of de   | ath 5∟                       | Other (sp                            | oecify)                    |  |            |                              |                          |                             |                    |  |
| Ž.        | requires that the<br>leen signed by th<br>hould be detache   |                | Part II. Other significant condition   | s contributing to death b                                     | ut not resul | Iting in the u               | nderlying o                          | ause give                  | on in Part I.  |            | 23e. Did t                   | obacco                   | use contribut               | e to the           | e cause of death?                            |
| ecoras,   | quires<br>n sign   | d by           |  |   |              |                              |                                      | -                          |  |            | 10                           | Yes 2                    | No 30                       | Proba              | ably 4 Unknown                               |
| 2         | law rec<br>as bee<br>2 shot  | olete          |  |   |              |                              |                                      |                            |  |            | 24a. Was                     | an                       | 24b. Were                   | autop              | sy findings available                        |
|           | iicien: The lav<br>certilicate has<br>rector, page 2 :   | Completed      |  |   |              |                              |                                      |                            |  | _          | autor<br>perfo               | psy<br>ormed?<br>2 Z No  | deat                        | h?                 | ipletion of cause of                         |
| VII all H | ysician:<br>is certifica<br>director, p  | BeC            | 25. Was case referred to medical examiner?   |   |              |                              |                                      |                            | 26. Place o  | f Death (  | Check only o                 |                          | , , ,                       | 103                |  |
| 5         | S 0  | ပ္             | 1 Yes 2 No   | Hospital: 1  Inpatie  |              | R/Outpatier                  |                                      |                            | 4 ( 14015  | ing Hom    | e 5 ☐ Resi                   | dence                    | 6 Other (                   | Specify,           | Daughters                                    |
|           | ding P.<br>h.<br>Alter I   | on:            | 27. Manner of Déath<br>1 ☑ Natural 5 ☐ Pending   | 28a. Date of Inju<br>(Month, Da)                              | y Year)      | 28b. Time o<br>Injury        |                                      | 28c. Injury<br>Work        |  |            | d. Describe                  | how inju                 | ry occurred                 |                    |  |
| DIVISION  | Attending Physicism: Ir death. sctor: After this certific by the funeral director,   | icat           | 2 Accident investiga 3 Suicide 6 Could no  | be 300 Blace of Init  | uny - At hor | mo tarm str                  | M factor                             |                            | fes 2 □ No   |            | If Location /                | Ctroot -                 |                             | - Duni             | Route Number.                                |
| 2         | spitel or Attending Phous effer death. Increi Director: After the  | Certification: | 4 Homicide determin  | building, et  | c. (Specify) | )                            | eet, lactor                          | y, onice                   |  | 20         | City or To                   |                          |                             | rnurai             | Houle Number,                                |
|           | To the Hospitel or Attendi<br>within 24 hours efter death.<br>To the Funeral Director: A<br>completely filled in by the fu   | Medical        | 29a. Certifier 1 Certifying (Check only one) 1 Medical Ex  | Physician: To the best aminer: On the basis of and manner sta | examinati    | vledge, deat<br>on and/or in | h occurred<br>vestigation            | at the time<br>t, in my op | e, date and printed and printe | place, an  | d due to the<br>at the time, | cause(s<br>date and      | ) and manne<br>d place, and | r as sta<br>due to | ated.<br>the cause(s)                        |
|           | To th<br>withir<br>To th<br>comp   | Me             | 29b. Signature and title of certifier  | 1/  |              |                              | 29                                   | License                    | number   |            |                              |                          | te signed (M                |                    | Day, Year)                                   |
|           | /  |                | 1 Philip 1   | Tous  |              |                              | 1                                    | 124                        | 321  |            |                              | 12                       | 4/23/                       | 02                 |  |
|           | 5  |                | 30. Name and address of person wh  |   | eath (Item   | 23а) (Туре,                  | Print)                               |                            |  | -          | ) 11 .                       |                          | -01                         |                    |  |
|           |  |                | 7:777-   | Conits 8  |              |                              | tut                                  | an s                       | treet  | K          | a Him                        | 619                      | Mid ?                       | 12                 | 61   |
|           | Sta<br>Registr   |                | 31. Date filed (Month, Day, Year)  DFC 9 7 20  | 32 Registra   | ar s Signati | иге                          | all's                                |                            |  |            |                              |                          |                             |                    |  |

|  |                  | For State   | State of Marylan  | d / Depa                        |  | lealth and                                | Mental Hygi                                     | •                                       | 41726  |
|--|------------------|---|---|---------------------------------|--|---|---|---|--|
|  |                  | Registrar  1. Decedent's Name (First, Middle, Last)   |   |                                 | tinoato or   | Douin                                     | 2. Date of Death                                |   | 3. Time of Death                                   |
| Physic   | ian              |   | 1 Putman  |                                 |  |   | December  |   |  |
| /Med   |                  |   |   |                                 |  |   |   |   |  |
| Exam   | iner             | 4a. Fecility Name (If not institution, give s   |   |                                 |  | or Location of Deat                       | h   | 4c. County of De                        |  |
|  |                  | Westminster Nursin  |   |                                 | Westmi   |   |   | Carro:                                  |  |
| Funera<br>Directo  |                  | 219-10-3812 A   | M 2□ F 7. Age (In yrs. 81   | last birthday)<br>Yrs.          | If Under 1 Year<br>Months Days                               | If Under 24 Hrs<br>Hours Min.             |   | 9. E<br>1924                            | lirthplace (State or Foreign<br>Country)<br>MD     |
| and *  |                  | Usual Residence of Decedent  10a. State 10b. County   | 10c. Cit  | v. Town or Lo                   | cation   |   |   | ·                                       | 10d. Inside City Limits                            |
| lanyli<br>eho  | ħ                | MD Carroll  |   | Westm                           | inster   |   |   |   | 1 ☐ Yes 2 ☐ No                                     |
| he N   | ect              |   |   |                                 |  |   | 100   | - 022                                   |  |
| with t   | Funeral Director | 10e. Street and Number  | D - 1   |                                 | 10f. Zip Code  |   | 10  | g. Citizen of What                      | Country?   |
| ath \ 8 232  | īa               | 320 East Nicodemus  |   |                                 |  | 21157                                     |   | USA                                     |  |
| er de<br>tem   | nue              | Ti Maria Gatos  | <ol><li>Was Decedent Ever in U.<br/>Armed Forces?</li></ol>                       | .S.   13. \                     | Was Decedent of H<br>f Yes, specify Cubi                     | Hispanic Origin? (S<br>an, Mexican, Puer  | Specify Yes or No-<br>to Rican, etc.)           | 14. Hace - Ar<br>Black, Wi              | nerican Indian,<br>nite, etc.                      |
| s afte   | by F             | 1 Never Married 2 Married   | 1 ☐ Yes 2 ☐XNo<br>If Yes, Give  |                                 | 1 ☐ Yes 2 📉 No   | Specify:                                  |   | Specify: T                              | Vhite  |
| nour le la   | D D              | 3 Widowed 4 Divorced  | Year or Dates:  | 1 40 0                          |  |   |   |   |  |
| 72<br>nat  | Completed        | 15. Decedent's Educ<br>(Specify only highest grade  | ation<br>completed)   | 16a. Deced                      | dent's Usual Occup<br>kind of work done<br>DO NOT use retire | ation<br>during most of wo                | rking   | 6b. Kind of Busines                     | is/Industry  |
| A Mithir   | 臣                | Elementary/Secondary (0-12)   | College (1-4or 5+)  | 1                               | nry Contr  |   |   | Maganar                                 |  |
| IIIQ X IX I 3-0030 be filed within 72 hours after death with the Maryland tal Hygiene. d other than "naturel", or items 23a or 28a-f show event, Ire Medical Evanfrer man be natilised at  |                  | 17. Father's Name (First, Middle, Last)   |   | Hason                           | iry contr  | T   | me (First, Middle, M                            | Masonry                                 |  |
| be fife doth of oth  | Be               | Archie Putman   |   |                                 |  | I   | B. Ramsbu                                       |   |  |
| should and Men marke   | 2                |   |   |                                 |  |   |   | 0                                       |  |
| 2 sh<br>and<br>ls m  |                  | 19a. Informant's Name/Relationship (Typ   |   |                                 |  |   | ural Route Number,                              | _                                       |  |
| and and health m 27  |                  | Mrs. Lillian A. Put   |   |                                 |  |   | ad Westmi                                       |   |  |
| Pages 1<br>nent of H<br>int: If ite  |                  | 20a. Method of Disposition<br>1 ☑ Burial 2 ☐ Cremation 3 ☐ Re   | emoval from State   | emetery, crer                   | sition (Name of<br>natory or other place                     | ce)                                       | Date 2  | Oc. Location - City                     | or Town, State                                     |
| Dallillore, Mal yiallo A 12.13-0050 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "naturel", or Items 23a or 28a-1 show any injury or other treumatic event, it a Medical Examinating an any injury or other treumatic event. |                  | `4 ☐ Donation 5 ☐ Other (Specify)   |   | ringfie                         | eld Cemet  | ery 12/3                                  | 0/2005 S  | ykesville                               | e, MD  |
| epari<br>epari<br>npor<br>ny in  |                  | 21. Signature of Funeral Service License  | 1/1/  |                                 |  |   | E & CHAPE                                       |   | ox 195)  |
| n goema  | Si .             | plia a T  | auget   |                                 |  |   | 84 (410)-                                       |   |  |
| Dhysisian  |                  | 23a. Part <sup>1</sup> . Enter the disease, or complic<br>shock, or heart failure. List only on<br>Immediate Cause (Final         | eations hat caused the death<br>e cause on each line.                             | h. Do not ent                   | er the mode of dyir  | ng, such as cardia                        | c or respiratory arres                          | st,                                     | Approximate<br>Interval Between<br>Onset and Death |
| Physiciar<br>/Medica   | _                | disease or condition resulting in death)  | Due to (or as a conseq  | uanca of)-                      | y 2m   | our                                       |   |   | 24 hour  |
| Examine  |                  |   | artis   | <                               | b. A   | · Mari                                    | ulur D  | 10000                                   | 200  |
|  | ē                | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events | Due to (or as a conseq  | uence of):                      | enju   | Lywie                                     | wire to   | Minut                                   | 270  |
| ansit B  | 듵                | Cause. Enter Underlying Cause (Disease or injury  | Demin   | tra                             |  |   |   |   | 7 Mai  |
| be executed icien and burial-transit   | Examiner         | resulting in death) Last  | Due to (or as a conseq  | uence of):                      |  |   |   |   | 1  |
| wrequires that the death certificate be executed been signed by the attending physicien and should be detached for use as the burial-transit   | cai              | d   | ,   |                                 |  |   |   |   |  |
| g phy<br>as th   | ledi             |   |   |                                 |  |   |   |   |  |
| n cert   | 2                | IF FEMALE: 23b. Was decedent pregnant 23  | Bc. If yes, outcome of pregna   |                                 | ne   |   |   | 23d. Date of d                          | elivery  |
| death death  | icia             | in the past 12 months?<br>1 ☐ Yes 2 ☐ No  | 1 ☐ Live birth 2 ☐ Feta<br>4 ☐ Pregnant at time of d                              |                                 | ]Ectopic pregnancy<br>] Other (specify) _                    | у   |   | Month                                   | Day Year   |
| of the ache  | Physician/Med    | 9 Unknown   | 9□ Unknown  |                                 |  |   |   |   |  |
| The Cords, F.O. BOX 00 The law requires that the death certifica tie has been signed by the attending ph page 2 should be detached for use as it   | by P             | Part II. Other significant conditions con   | tributing to death but not res  | ulting in the u                 | nderlying cause giv  | en in Part I.                             | 23e. Did toba                                   | cco use contribute                      | to the cause of death?                             |
| w requires been sign should be   |                  |   |   |                                 |  |   | 1 🗌 Yes   | 2 3 Ho 3 1                              | Probably 4 Unknown                                 |
| w w s  | jet              |   |   |                                 |  |   | 24a. Was an                                     | 24b. Were                               | autopsy findings available                         |
| VICAL THE Geiclen: The law scrifficate has birector, page 2 s  | ompieted         |   |   |                                 |  |   | autopsy   | ed? death                               | completion of cause of                             |
|  | Ö                | 25. Was case referred to medical  |   |                                 |  | 26 Place of De                            | 1 Yes 2€<br>ath (Check only one,                |   | as 2□ <del>No</del>                                |
| OI VILA Physicien: rthis certific ral director,  | 0 B              | examiner?<br>1 ☐ Yes 2 ☐ No   | ospital:  | FR/Outnation                    | t 3D DOA Ott   |   | Home 5 Residen                                  |   | necifi()   |
| ding Phys  | =                | 27. Manner of Death   | 28a. Date of Injury   | 28b. Time of                    | 28c. Injur   | ry at                                     | 28d. Describe how                               |   | outy)  |
| or Afte  | 皇                | 1 ☐Natural 5 ☐ Pending 2 ☐ Accident investigation   | (Month, Day Year)   | Injury                          | M 1 🗆  | rk?<br>Yes 2 □ No                         |   |   |  |
| Attending at death.  | ifica            | 3 Suicide 6 Could not be  | 28e. Place of Injury - At he  | ome, farm, str                  | eet, factory, office   |   |   |   | Rural Route Number,                                |
| a afte   | Certification:   | 4 Homicide  | building, etc. (Specif  | y)                              |  |   | City or Town,                                   | State)                                  |  |
| To the Hospitel or Attendi<br>within 24 hours after death.<br>To the Funerel Director: A<br>completely filled in by the fu   | Medical (        | 29a. Certifier 1 Certifying Phys (Check only one) 2 Medical Exemin  | ician: To the best of my kno<br>er: On the basis of examina<br>and manner stated. | wledge, death<br>tion and/or in | occurred at the tirvestigation, in my o                      | me, date and place<br>opinion, death occu | e, and due to the cau<br>urred at the time, dat | ise(s) and manner<br>e and place, and d | as stated.<br>ue to the cause(s)                   |
| To th<br>withir<br>To th   | Me               | 29b. Signature and title of certifier   | 100   |                                 | 29c. Licens  | se number                                 | 290   | d. Date signed (Mo                      | nth, Day, Year)                                    |
| ,  |                  | > Chila hli   | mild 1.7  | <u> </u>                        | D2   | 5443                                      |   | 12/241                                  | 105  |
| 1  | 2                | 30. Name and address of person who con  | mpleted cause of death (Iten  | 1 23a) (Type,                   | Print)   | 1 / 2                                     |   | 1-10-11                                 |  |
| 1  | 2                |   |   |                                 |  |   |   |   |  |
| V  |                  | John W. M.  | ldu ion 6   | 18 Po                           | de Rou   | of We                                     | strumini  | ta mr.                                  | 72116  |
|  | tate             | DEC 2 7 2005  | Let U if on Let   |                                 | de Rou   | of Wa                                     | stmins  | to mi                                   | 72116  |

Physicia /Medic Examin

**Funeral** Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other then "naturel", or items 23a or 28a-f show any injury or other traumatic event. The Medical Examiner must be nutified at once.

Physician /Medical Examiner

To the Hospitel or Attending Physician: The law requires that the death certificete be executed within 24 hours efter death.

To the Funeral Director: After this certificete hes been signed by the ettending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

| <ul><li>State</li><li>Registrar</li></ul>  |  |   |  | a. ,   | /land / D  | •  | cate of  |  |   |                    |  | Reg. No.  | LU  | 05   | 4172   |
|--|--|---|--|--|--|--|--|--|---|--------------------|--|---|---|--|--|
| Decedent's N   | lame (First, Midd  | dle, Last,  | )  |  |  |  |  |  |   |                    | Date of De   |   | V   | - Xon-   | 3. Time of Death   |
| Charle   | es H. Po   | wel:  | 1  |  |  |  |  |  |   | DE                 | CEMB   | ERT   | 75, 2   | 2005   | 9:56 A   |
| . Facility Nam   | ne (If not institution   | on, give  | street and nu  | umber)   | -  | 4b.  | City, Town,  | or Location  | of Death  | 1                  |  | 4c.   | County  | of Death   | 1  |
| 511 HI   | ILL TOP  | DRIV  | 7E   |  |  | 1  | CUMBE  |  |   | _                  |  | _   | LLE   | GANY   |  |
| Social Securit   |  | 6. Se:  | x<br>∂M 2□F  |  | yrs. last birt   | Mo   | Under 1 Yea<br>onths Day   |  | er 24 Hrs.<br>Min.  | 8. [               | Date of Bir<br>Month, Da   | y, Year)  |   |  | place (State or Fore<br>intry)   |
| 215-42-  |  | . 2   | 5  | (  | 52   | Yrs.   |  |  |   | Ju                 | ıly 9  | , 19  | 43  | Mary   | land   |
| sual Residenc<br>Da. State   | e of Decedent<br>10b. Count  | ty  |  | 10   | c. City, Town  | or Locatio   | n  |  |   |                    |  |   |   |  | 10d. Inside City Lim   |
| MD   | Alle   | anv   |  |  | Cumb   | berla:   | nd   |  |   |                    |  |   |   |  | 1 ☐ Yes 2√2 N  |
| De. Street and   |  | gany  |  |  | Odini  |  | Of. Zip Code   |  |   |                    |  | 10g. Citi   | izen of V   | What Cou   | untry?   |
|  | Hill To  | p Dr  | ive  |  |  |  |  | 2150   | )2  |                    |  |   |   | JSA  |  |
| 1. Marital State   |  | P 22  | 12. Was Dec  | cedent Eve   | r in U.S.  | 13. Was  | Decedent of  | Hispanic C   | Origin? (Sp   | pecify             | Yes or No  | )-  | 14. Rac   | e - Amer   | ican Indian,   |
|  | varried 2⊠ Ma  | tried   | Armed F  | orces?   |  | If Yes   | s, specify Cu  | ban, Mexic   | an, Puerto  | o Rica             | n, etc.)   |   |   | ck, White  |  |
|  | ed 4 Divorce   |   | If Yes, G<br>Year or I   | 2 □ No<br>live<br>Dates:   |  | 101  | ∕es 2XIN   | o Specify  | fy:   |                    |  |   | Specify   | y: wh  | ite  |
|  | 15. Decede   |   |  | 0  | 16a.   | Decedent's   | s Usual Occ  | upation  | net of  | tin-               |  | 16b. K  | ind of B  | usiness/l  | ndustry  |
|  | Specify only high<br>Secondary (0-12)  | 1   |  | (1-4or 5+)   |  | life. DO N   | of work don<br>IOT use retii   | ed)  | USI OF WOR  | riig               |  |   |   |  |  |
| 12   |  |   | 0  | /  |  | labor  | er   |  |   |                    |  | С   | 1oth  | ning   |  |
| 7. Father's Na   | me (First, Middle  | e, Last)  |  |  |  |  |  | 18. Mot  | her's Nam   | ne (Fir            | st, Middle,  | Maiden  | Suman   | ne)  |  |
| Huey H   | Powell   |   |  |  |  |  |  |  | Lo1   | La I               | rost   |   |   |  |  |
|  | 's Name/Relation   |   |  |  |  |  | idress (Stree  |  |   |                    |  |   |   |  |  |
| Clara  | Powe11/  | spou  | ıse  |  | 5  | 11 Hi  | 11 Top   | Driv   | ve Cu   | ımbe               | erlan  | d, M  | D 2   | 21502  | 2  |
| 0a. Method of  | •  |   | Domessel for   |  | 20b. Place of<br>cemeter   | Disposition  | n (Name of<br>ry or other p  | ace)   |   | Date               |  | 20c. Lo   | ocation -   | City or 1  | Town, State  |
| _  | 2 ☐ Cremation ion 5 ☐ Other  |   |  | n State  |  |  |  | 1  |   |                    |  |   |   |  |  |
| 1. Signature o   | of Funeral Service   |   |  | Dimoo  | +  | 22. Na   | me and Add   | ress of Fac  | nlity   | <b>.</b> .         | 5  | D o 1   | ئاما ا  |  | Street   |
| Les  | non de   | 7/1   | XXX  | Direc  | ع بيار   | Stat   |  |  | DOME  |                    |  |   | 1111111111111   | are  | SITEPI   |
| 23a. Part1. Ent  | 10   |   | / 00   |  |  |  | imore  |  | 2120  |                    | . w  | Dal   | LULIII  | 010  | Derece   |
| shock or   | ter the diséase,   | or comp   | lications that   | caused the   | death. Don   | Balt   | imore  | , MD   | _2120   | 01_                |  |   |   |  | Approximate  |
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|--------------------|---|-------------------|---|--|--|--|---------------------------|--------------------|---------------------|---------------|--|-----------------------------|------------------------|--|
|                    |   |                   | 1. Decedent's Name (First, Middle, Last   | )  |  |  |                           |                    |                     | 2.            | Date of Dear                           | th<br>Day                   | Year                   | 3. Time of Death                             |
|                    | Physicia<br>/Medic  |                   | Milton F. Quas  | ney  |  |  |                           |                    |                     | D             | ecembe                                 |                             | 2005                   | 8:15 AM M                                    |
|                    | Examin  |                   | 4a. Facility Name (If not institution, give   | street and number)   | -  |  | 4b. City,                 | Town, or           | Locetion o          | f Death       |  | 4c. Coun                    | ty of Deatl            |  |
|                    |   |                   | Charlestown Re  |  |  |  |                           | onsv               |                     | 2711          |  |                             | imor                   |  |
|                    | Funeral<br>Director   |                   | 213-22-14/6   | X 7. Ag  | ge (In yrs. last I<br>78                 | Yrs.   | If Under<br>Months        | 1 Year<br>Days     | If Under 2<br>Hours | Min. S        | Date of Birth<br>(Month, Day<br>2pt 20 | Year)<br>1927               | Co                     | nplace (State or Foreign<br>untry)<br>'Yland |
|                    | pu s  | -                 | Usual Residence of Decedent  10a. State 10b. County   | <del> </del>   | 10c. City, To                            | wn or Lo   | cation                    |                    |                     |               |  |                             |                        | 10d. Inside City Limits                      |
|                    | sho   | ō                 | MD Baltimore  |  |  |  | ville                     |                    |                     |               |  |                             |                        | 1 ☐ Yes 2 ☐ No                               |
|                    | 28a-1   | Funeral Director  | 10e. Street and Number  |  | Ua Ua                                    | COIIS  | 10f. Zip                  |                    |                     |               | 1                                      | 0g. Citizen of              | What Co                | A  |
|                    | with with   | Ö                 | 709 Maiden Choice   | Tane #35   | 502                                      |  | 2                         | 1228               |                     |               |  | USA                         |                        |  |
|                    | heath   | era               | 11. Marital Status  | 12. Was Decedent   | Ever in U.S.                             | 13.  | Was Dece                  | dent of Hi         | spanic Orig         | gin? (Specif  | y Yes or No-                           | 14. Ra                      |                        | rican Indian,                                |
| 99                 | within 72 hours after death with the Maryland<br>ene.<br>Itan "natural", or items 23a or 28a-f show<br>the Madical Examinat must be modified at   | y Fur             | 1 Never Married 2 Married   | Armed Forces'<br>1 MYes 2 ☐<br>If Yes, Give                | No                                       |  | it Yes, spec<br>1 ☐ Yes   |                    | Specify:            | , Puerto Ric  | an, etc.)                              |                             | ack, White<br>ify: whi |  |
| 21215-0036         | ural',  | d by              | 3 ☑ Widowed 4 □ Divorced  | Year or Dates:   | 45-49                                    | Sa Dooo  | dent's Usua               | al Occupa          | tion                |               |  | 16b. Kind of                |                        |  |
| 7                  | n 72<br>"nat  | Completed         | 15. Decedent's Edi<br>(Specify only highest grad  | fe completed)  |  | (Give  | kind of wo<br>DO NOT u    | rk done a          | luring most         | t of working  |  | 100. Killa ol               | Dusiness/              | industry                                     |
| 12                 | withi   | шo                | Elementary/Secondary (0-12)   | College (1-4or<br>4  | 5+)                                      | er   | ngine                     | er                 |                     |               |  | ind                         | dustr                  | ial  |
| 0                  | Hyg<br>other<br>ant.  | BeC               | 17. Father's Name (First, Middle, Last)   |  |  |  |                           |                    | 18. Mothe           | ir's Name (F  | irst, Middle,                          | Maiden Suma                 | ıme)                   |  |
| /lan               | utd be<br>Menta<br>Irked<br>Itic ev   | To B              | Michael Quasne  | У  |  |  |                           |                    |                     | Edna          | Lulie                                  |                             |                        |  |
| lar                | 2 sho<br>and h<br>is ma   |                   | 19a. Informant's Name/Relationship (7   |  |  |  | •                         |                    |                     |               |  | r, City or Tow              |                        |  |
| <u>√</u>           | and<br>lealth<br>m 27<br>her tr   |                   | George Hauver/gran  | idson  | 20b. Place                               |  |                           |                    | l Par               | k Roa         | -                                      | erick,                      |                        | 21702  |
| altimore, Maryland | Pages 1<br>nent of H<br>int: If ite<br>iry or ot  |                   | 20a. Method of Disposition  1 □ Burial 2 □ Cremation 3 □  4 □ Donation 5 □ Other (Specify                   |  | como                                     | tery, crei   | matory or o               | ther place         | 9)                  | 54.           |  | 200. Coddio                 | i oly or               | TOWN, State                                  |
| Balti              | permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.  Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event. It is Marylan Examinal must be notified at once. |                   | 21. Signature of Funeral Service Licens Ronald S.   | Wade Dir   | ector                                    |  | tate<br>altim             |                    | -                   | oard<br>21201 | 655 W.                                 | Balti                       | mroe                   | Street                                       |
|                    |   |                   | 274. Part 1 Enter the disease, or comp<br>shock, or heart failure. List only                                | lications that cause                                       | d the death. D                           |  |                           |                    |                     |               | espiratory arr                         | est,                        |                        | Approximate<br>Interval Between              |
|                    | Physician   |                   | Immediate Cause (Final disease or condition   | and outso on outsi   | 1  | heus   | more                      | ia                 |                     |               |  |                             |                        | Onset and Death                              |
|                    | /Medical<br>Examiner  |                   | resulting in death)   | Due to (or as  | s a consequent                           |  |                           |                    |                     |               |  |                             |                        |  |
|                    |   | Jer.              | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | b. Due to (or as   | s a consequenc                           | se of):  |                           | _                  |                     |               |  |                             |                        |  |
|                    | ocuted<br>nd<br>transit   | Examiner          | that initiated events   | c  |  |  |                           |                    |                     |               |  |                             |                        |  |
| 8760,              | ate be executed<br>hysician and<br>the burial-transit   |                   | resulting in death) Last  | Due to (or as  | s a consequenc                           | ce of):  |                           |                    |                     |               |  |                             |                        |  |
| 687                | physics the l   | dica              |   | d  |  |  |                           |                    |                     |               |  |                             |                        |  |
| O.                 | that the death certificate be executed<br>ed by the attending physician and<br>detached for use as the burial-transit   | Physician/Medical | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown                     |  | e of pregnancy<br>2                      | ath 3[   | ⊒Ectopic p<br>⊒ Other (sp |                    |                     |               |  |                             | ate of del             | ivery<br>Day Year                            |
| Ф                  | Se un ec  | by                | Part II. Other significant conditions of  | ontributing to death                                       | but not resultin                         | g in the u   | Inderlying o              | ause give          | en in Part I.       |               |  | bacco use co                | ntribute to            | the cause of death?                          |
| Vital Records,     | w require<br>been si<br>should b  | Completed         | Atvi  | al Pain  | Culla                                    | tion   |                           |                    |                     |               | 24a. Was a                             |                             | . Were au              | topsy findings available                     |
| Re                 | The lav   | ошр               |   | 700  |  | 0-0  |                           | _                  |                     |               | autops<br>perfor                       | med?<br>2 No                | death?                 | completion of cause of<br>2□ No              |
| tal                |   | 0                 | 25. Was case referred to medical  |  |  |  |                           |                    | 26. Place           | of Death (    | Check only or                          |                             |                        |  |
| >                  | Q S   | To B              | examiner?<br>1 □ Yes 2 □ No   | Hospital: 1   Inpat  | ient 2 ER/                               | Outpatie   | nt 3 🗆 D0                 | OA Othe            | er: 42 Nu           | irsing Home   | 5 🗆 Resid                              | ence 6 🗆 O                  | ther (Spe              | cify)  |
| J Of               |   |                   | 27. Manner of Death 1 ☑Natural 5 ☐ Pending  | 28a. Date of Inj<br>(Month, D                              | ury 28                                   | b. Time o  | of 3                      | 28c. Injun<br>Worl | at<br>c?            | 280           | d. Describe h                          | ow injury occ               | urred                  |  |
| ioi                | Vttendir<br>death.<br>ctor: Af<br>y the fu  | satic             | 2 ☐ Accident investigation  |  |  |  | М                         |                    | Yes 2□              |               |  |                             |                        |  |
| Division           | al or Attend<br>a after death<br>I Diractor:<br>d in by the f   | Certification:    | 3 ☐ Suicide 6 ☐ Could not be<br>4 ☐ Homicide determined   | 28e. Place of Ir<br>building, e                            | njury - At home<br>atc. <i>(Specify)</i> | , farm, st   | reet, factor              | y, office          |                     | 28            | f. Location (S<br>City or Tow          | itreet and Nur<br>n, State) | nber or Ru             | ıral Route Number,                           |
|                    | To the Hospital or Attending within 24 hours after death.  To tha Funeral Diractor: After completely filled in by the fune  | edicai C          |   | ysician: To the bes<br>niner: On the basis<br>and manner s | of examination                           |  |                           |                    |                     |               |  |                             |                        |  |
|                    | To th<br>within<br>To th<br>compl   | Me                | 29b. Signature and title of certifier   | Jan  | NHO                                      | 9  |                           | c. Licens          |                     | 040           |  | 29d. Date sign              | ned (Monti             | h, Day, Year)                                |
| ,                  |   |                   |   | completed cause of   | death (Item 23                           | la) (Type,   | Print)                    | 1/                 | dia.                | 1040          |  |                             | all                    | man 20.                                      |
|                    |   |                   | 31. Date filed (Month, Day, Year)   | LUI 7  | trar's Signature                         | 100  | all                       |                    | p uzc               |               | cau                                    | ·                           | - co                   | 46   |
|                    | St:<br>Regist   | ate<br>rar        | DEC 2 7 2005  |  | , K                                      | A CONTRACTOR OF THE PARTY OF TH | D                         |                    |                     |               |  |                             |                        | 2/228  |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Year Margaret Hamma

4a. Facility Name (If not institution, give street and number) hammine 24. Decembe: 2005 /Medical 4c. County of Death 4b. City, Town, or Location of Death Examiner Battinge If Under 1 Year | If Under 24 Hrs. Harfold Road Old 5. Social Security Number 7. Age (In yrs, last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 M 2 F Hours Yrs. Director 220-09-4546 Maryland Usual Residence of Decedent 10h County 10c. City, Town or Location 10a. State 10d. Inside City Limits or Items 23a or 28e-1 show uner rount be notified at 1 ☐ Yes 3 No Completed by Funeral Director Battmore Baltimore ND 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Book 21234 SA tartord 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ō 1 ☐ Yes 2 ☑ No Specify: Specify: 3 ☑ Widowed 4 ☐ Divorced White treumatic event, the Mudical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) than College (1-4or 5+) al Hygiene. Elementary/Secondary (0-12) UNK. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be t nent of Health and Mental F int: If item 27 Is marked of Rede 10pg P trances Emge 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Regina Rawlings -daughter 20a. Method of Disposition 20b. 1 old Harroad, Baltimore Maryland 21234
Date 20c. Location - City or Town, State item 2 20b. Place of Disposition (Name of cemetery, crematory or other place) Department of H Important: If its eny Injury or ot once. 1 Burial 2 Cremation 3 Removal from State Parkwood Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 282005 Parkville, Maryland 22. Name and Address of Facility Evans chopel of memories 21. Signature of Fungral Service Ligensee 8800 milane Harford Good-Parkville Maryland 2/234 23a. Part I. Enter the disease, or comprigations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** HERATIC FAILURE disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** METASTATIC ABENOCHECINOMA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner CARENVOMA OF Hospitel or Attending Physicien: The law requires that the death certificate be executed burial-transit THE PANCREAS Due to (or as a consequence of): Physician/Medical the IF FEMALE: esn 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No for 4 Pregnant at time of death 5 Other (specify) o ۵. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records. Be Completed by C.O. P.D 1 Yes 2 No 3 Probably 4 Dunknown SENILE DEMENTIA 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No N∕A 1□ Yes 2⊠ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA 2 1 Yes 2 No this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Certification: NIA Division 1 Natural 5 Pending NIA death. 1 TYes 2 Accident investigation after death Director: 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide NIA Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical within 24 ho To the Fund completely f 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

State Registrar 31. Date filed (Month, Day, Year)

SERENA R. NOLAN MD

29b. Signature and title of certifier

32. Registrar's Signature

Nolow MA

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

8831 SATYR HILL RD SUITE 100

29c. License number

00025010

29d. Date signed (Month, Day, Year)

PARKVILLE, MD

DECEMBER 27, 2005

21234

|        |             |   |                  | 1 - State<br>Registrar   | Department of Health a Certificate of Death                                | Reg   | a.005 41730  |
|--------|-------------|---|------------------|--|--|---|--|
| _      |             | Physici<br>/Medic   |                  | 1. Decedent's Name (First, Middle, Last)  Deborah Jean Reinker   |  | 2. Date of Death  | Day 20 Year 3. Time of Death /340 M  |
|        |             | Examin  |                  | 4a. Facility Name (If not institution, give street and number)   | 4b. City, Town, or Location  | of Death  | 4c. County of Death  |
|        |             |   |                  | Upper Chesapeake Medical Center  | Bel Air  | 24 1470   | Harford  |
|        |             | Funeral<br>Director   |                  | 210-00-0433 47   | thday) If Under 1 Year If Under Year Months Days Hours                     | 8. Date of Birth<br>(Month, Day, )<br>Nov. 27,                | 9. Birthplace (State or Foreign Country) 1958 Maryland                     |
|        |             | land ow   |                  | Usual Residence of Decedent  10a. State 10b. County 10c. City, Town  | 1 or Location  |   | 10d. Inside City Limits  |
|        |             | Mary<br>1 sh  | tor              | Maryland Harford Be  | el Air   |   | 1 ☐ Yes 2 XNo  |
| 2      | •           | or 284  | Jirec            | 10e. Street and Number   | 10f. Zip Code  | 100   | . Citizen of What Country?   |
| 0      |             | ath w   | ral              | 3 Brooks Road  | 21014  |   | USA  |
| 0      |             | er de   | Funeral Director | 11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 □ Never Married 2 ☑ Married  1 ☑ Yes 2 □ No   | 13. Was Decedent of Hispanic Ori<br>If Yes, specify Cuban, Mexican         | igin? (Specify Yes or No-<br>n, Puerto Rican, etc.)           | 14. Race - American Indian,<br>Black, White, etc.                          |
| 2      | 920         | urs aff   | þ                | 3 Widowed 4 Divorced Year or Dates:  | 1 ☐ Yes 2 No Specify:  |   | Specify: White   |
| 34     | 5-0036      | within 72 hours after death with the Maryland<br>liene.<br>r then "natural", or items 23e or 28e-f show<br>the Medical Examinar must be notified at           | Completed        | 15. Decedent's Education 16a. (Specify only highest grade completed)   | Decedent's Usual Occupation (Give kind of work done during mos             | at of working   | 6b. Kind of Business/Industry  |
| 1      | 2           | within<br>ene.<br>then "  | mple             | Elementary/Secondary (0-12) College (1-4or 5+)   | life. DO NOT use retired)  | a or tronsing   |  |
|        | 121         | Hyg<br>It,  | S                | 12<br>17. Father's Name (First, Middle, Last)  | Homemaker  | er's Name (First, Middle, Ma                                  | Own Home   |
|        | ano         | a ta b  | To Be            | Eugene Henry Sanderlin   |  | ecca Helen  |  |
| 52     | Maryland    | and<br>and<br>is m  | -                | 19a. Informant's Name/Relationship (Type, Print)   | . Mailing Address (Street and Numb<br>3 Brooks Road, B                     |   |  |
| ~      | به د        | s 1 and of Health item 27 other tr  |                  | 20a Method of Disposition 20b. Place of  | Disposition (Name of   |   | Oc. Location - City or Town, State   |
| X      | E G         |   |                  | 1 Liburiai 2 Ni Cremation 3 Li Removal from State  | ry, crematory or other place) op Service Corp.                             | 12-24-05 To   | owson, Maryland  |
| 7      | Baltimor    | permit. Page<br>Department (<br>important: if<br>eny injury or<br>once.   |                  | 21. Signature of Funeral Service Licensee  | 22 Name and Address of Facili<br>McComas Funera                            |   |  |
| 6      | 8           | 80 E 8 8  |                  | 1 Kussel Slig  | 1317 Cokesbury   | Road, Abing   | lon, Maryland 21009  |
|        |             | Physician<br>/Medical<br>Examiner   |                  | 23a. Part1. Enter the disease, or complications that caused the death. Do shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence)  Sequentially list conditions.   | of):   | cardiac or respiratory arres                                  | t. Approximate Interval Between Onset and Death                            |
| 333020 | Ø,09289     | The law requires that the death certificate be executed as been signed by the attending physicien and page 2 should be detached for use as the burial-transit | dicai Examiner   | Sequentially list conditions, if any, leading to immediate characteristics of the control of the |  |   |  |
| #      | .O. Box (   | nt the death certific:<br>by the attending pl<br>tached for use as t  | Physician/Med    | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2   No 9   Unknown   22c. If yes, outcome of pregnancy 1   Live birth 2   Fetal death 4   Pregnant at time of death 9   Unknown   | 3 ☐ Ectopic pregnancy<br>5 ☐ Other (specify)                               |   | 23d. Date of delivery<br>Month Day Year                                    |
| bbje   | ds, F       | uires the<br>signed l   | by               | Part II. Other significant conditions contributing to death but not resulting is   | า the underlying cause given in Part l                                     | 1   | cco use contribute to the cause of death?  2 □ No 3 □ Probably 4 □ Unknown |
| Dek    | al Records, |   | Completed        |  |  | 24a. Was an autopsy perform                                   |  |
|        | Vital       | Physician: 1<br>this certifice<br>ral director, p   | Be               | 25. Was case referred to medical examiner?  Hospital:  |  | e of Death   Check only one                                   |  |
| 2r     | on of       | Phys<br>r this<br>ral dii   | ion: To          | 27. Manner of Death 1 Natural 5 Pending (Month, Day Year)  |  | ursing Home 5 Residen  28d. Describe how                      |  |
| ein K  | Division    | i or Attend<br>after death<br>Director: J   | Certification:   | 2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, fa building, etc. (Specify)   |  |   | net and Number or Rural Route Number,<br>State)                            |
| Re     | _           | To the Hospitei or Attending within 24 hours after death.  To the Funerel Director: After completely filled in by the fune                                    | dicai            | 29a Certifier (Check only one)  Certifying Physician T. the best of examination an and manner stated.  | s death occurred at the time date and/or investigation, in my opinion, dea | nd place, and due to the cau<br>ath occurred at the time, dat | e and place, and due to the cause(s)                                       |
|        |             | To the<br>within<br>To the  | Me               | 29b. Signature and title of certifier  | 29c. License number  | 290   | d. Date signed (Month, Day, Year)  |
|        |             | -   |                  | Darses Du  | 0322   | 55 D  | Jecta her 20, 2005   |
|        |             | 2+1   |                  | 30. Name and address of person who completed cause of death (Item 23a)   | (Type, Print)  |   |  |
|        |             | 9   |                  | 21 Date filed (Month Day Vard)   | macphal 0  | Beloirmo  |  |
|        | li d        | Sta<br>Regist   | ate<br>rar       | 31. Date filed (Month, Day, Year) DEC 2 7 2005   | and a  |   |  |

1 - For State Registrar

Certificate of Death

| Hygiei | пę | 0 | 0 | pro- |
|--------|----|---|---|------|
|        | 1  | U | U | D.   |

12/23/05

2401 West Belvedere Avenue

Baltimore, Maryland 21215

|                |  | e e                  | Decedent's Name (First, Middle, La                            | ist)  |                   |  |                                | 2. Date of Death                        |                       |              | 3. Time of Death                                   |
|----------------|--|----------------------|---|---|-------------------|--|--------------------------------|---|-----------------------|--------------|--|
|                | Physici  |                      | Rameshchan  | ira M. Shal   | h                 |  |                                | Month<br>DECEMBE                        | Day 2                 | Year<br>2005 | 13:50 M  |
|                | /Medic<br>Examin   |                      | 4a. Facility Name (If not institution, given                  |   |                   | 4b. City, Town, or   | r Location of Death            |   | 4c. County            |              |  |
|                |  |                      | SINAI HOSPHITA  | L OF BALTIN   | 4045              | BALTIM   | URE CI-                        | 7 🔾                                     | 'n                    | ı/a          |  |
|                | Funeral  |                      | 5. Social Security Number 6.                                  | Sex 7. Age (In yrs.   |                   | If Under 1 Year  | If Under 24 Hrs.               | 8 Date of Birth                         |                       | 9. Birthol   | ace (State or Foreign                              |
| ~              | Director   |                      | 219-72-6800   | 1⊠M 2□F 59  | Yrs.              | Months Days  | Hours Min.                     | (Month, Day, )<br>Aug 10,               |                       | Count        | dia  |
| 2              | D  |                      | Usual Residence of Decedent                                   |   |                   |  |                                | Aug IV                                  | 1940                  | T11.         | ura  |
| ē              | ylan   |                      | 10a. State 10b. County  | 10c. C  | ty, Town or Lo    | cation   |                                |   |                       | 10           | Od. Inside City Limits                             |
| AA             | Mar  | į.                   | Maryland Baltimo  | aro.  | D o               |  |                                |   |                       |              | 1 ☐ Yes 2 📉 No                                     |
| Į              | 1he  | Director             | 10e. Street and Number  | )16   | Ne                | isterstor  | WII                            | 100                                     | g. Citizen of W       | hat Coun     | trv?   |
| NAMESH CHANDRA | 5-0036 72 hours alter death with the Maryland natural', or Items 23a or 28a-f ahow lical Examinat he notilised at  | 0                    | 10 Deer Cross Co  |   |                   |  | 21126                          |   |                       |              |  |
| 7              | eath   | Completed by Funeral | 11. Marital Status  | 12. Was Decedent Ever in U                                    | 18 13 1           |  | 21136<br>lispanic Origin? (Spi | norfy Voc or No                         | Ind                   | · America    | on ladies  |
| Ā              | fler d   | Ę                    | 1 ☐ Never Married 2X Married                                  | Armed Forces?   |                   | f Yes, specify Cuba  | an, Mexican, Puerto            | Rican, etc.)                            |                       | c, White, e  |  |
| ξ              | 36   | ķ                    | 3 ☐ Widowed 4 ☐ Divorced                                      | 1 ☐ Yes 2 ☑ No<br>If Yes, Give<br>Year or Dates:              |                   | 1 ☐ Yes 2¶ No  | Specify:                       |   | Specify:              |              |  |
| Č              | 21215-0036 od within 72 hours att gjene. or than "natural; or the Medical Exami  | 듛                    |   |   | 100 D             | de este tito est Occasion  |                                |   |                       |              | an-Indian  |
|                | 27 2 2 2 2   | ete                  | 15. Decedent's E<br>(Specify only highest gr                  |   | (Give             | dent's Usual Occup:<br>kind of work done o<br>DO NOT use retired | during most of work.           | ing                                     | 6b. Kind of Bu        | siness/Ind   | lustry   |
| Ī              | within ene.  | 臣                    | Elementary/Secondary (0-12)                                   | College (1-4or 5+)  | <i></i>           |  | 1)                             |   |                       |              |  |
| I CI C         | d 2<br>Hilled<br>Hygie<br>ther   | ပိ                   | 17. Father's Name (First, Middle, Last                        | 5+  |                   | Doctor   | 40.04.4.4.4.4                  |   |                       | edica        | a1   |
| ית             | tal hid ot   | Be                   |   |   |                   |  |                                | e (First, Middle, Ma                    | aiden Sumami          | ∍)           |  |
| *              | Iryland 21215-003 should be tiled within 72 hours of Mental Hygiene. marked other than "natural; matic event, the Medical Exa  | ၉                    | Maneklal  | Shah  |                   |  | Chand                          | ramani                                  | Sukha                 | dia          |  |
| 2              | Maryland nd 2 should be lile lilh and Mental Hy 27 is marked oth   |                      | 19a. Informant's Name/Relationship                            | (Type, Print)   | 19b. Mailir       | ng Address (Street   | and Number or Rura             | al Route Number, (                      | City or Town, S       | State, Zip   | Code)  |
|                | Nore, Maryland 21215-0036 ges 1 and 2 should be tiled within 72 hours atter death with the Marylan tt of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23s or 28s-1 show or other traumatic event, the Modical Examinar must be notified at | 3                    | Jagdish Parikh/B  | other   | 209 A             | rgosy Dri  | ive Gait                       | hersbur.                                | Maryl                 | and 2        | 20878  |
| ¥              | Baltimore, permit. Pages 1 an Depertment of Heat Important: if item 2 any injury or other  | 1                    | 20a. Method of Disposition                                    |   | Place of Dispo    | sition (Name of natory or other place                            |                                |   | c. Location - 0       |              |  |
| PATIENT        | Page<br>Page<br>lent of<br>nt: If  |                      | 1 ☐ Burial 2 🛣 Cremation 3 [<br>4 ☐ Donation 5 ☐ Other (Speci | _Removal from State   | -                 |  | atory 12/                      | 26/2005                                 | Odento                | n M          | aruland  |
| 1-             | T September 1  |                      | 21. Signut re of Funeral Service Lice                         |   | 22                | . Name and Addres  | ss of Facility                 |   |                       |              |  |
| 0              | Dep<br>Dep<br>Impo   |                      | Munich PU   | Romas MOOS  | D                 | onaldson   | Funeral                        | Home & Cr                               | remator               | у, Р         | . A .  |
|                |  |                      | 23a. Parti Enter the disease, or con                          |   |                   | 411 Annar  | polis Roa                      | d Odento                                | n, Mar                |              |  |
| -              |  |                      | snocky or near failure. List only                             | one cause on each line.                                       | III. DO NOL ONL   | er the mode of dyin  | ig, such as cardiac o          | or respiratory arres                    | τ,                    |              | Approximate<br>Interval Between<br>Onset and Death |
|                | Physician  |                      | Immediate Cause (Final disease or condition                   | a Acute R   | ESPIRATO          | RY DISTRE  | ESS SYND                       | RUME                                    |                       |              | 7 DAYS   |
| •              | /Medical<br>Examiner   |                      | resulting in death)   | Due to (or as a consec  | quence of):       |  |                                |   |                       |              |  |
|                | LAdilillei   |                      | Sequentially list conditions,                                 | b. MYDCARD  | AL                | NEARKTI  | ON                             |   |                       | 107          | 30445  |
|                | . B =  | ner                  | if any, leading to immediate cause. Enter Underlying          | Due to (or as a consec  | quence of):       |  |                                |   |                       |              | -  |
| 10             | executed<br>n end<br>ial-transit   | Examiner             | Cause (Disease or injury that initiated events                | c   |                   |  |                                |   |                       |              |  |
|                | D,<br>exe<br>an er<br>rial-tr  | Ĕ                    | resulting in death) Last                                      | Due to (or as a consec  | quence of):       |  |                                |   |                       |              |  |
|                | 76<br>e be<br>sicire<br>sicire   | ia i                 |   | d   |                   |  |                                |   |                       | 4            |  |
|                | ficat<br>ficat<br>s phy  | edi                  |   |   |                   |  |                                |   | 1826                  |              |  |
|                | Box 68760, Continued to executed attending physician and for use as the burial-transit   | Physician/Medical    | IF FEMALE:<br>23b. Was decedent pregnant                      | 23c. If yes, outcome of pregn                                 | ancy              |  |                                |   | 22d Date              |              |  |
|                | atter for u  | ciar                 | in the past 12 months?  | 1 ☐ Live birth 2 ☐ Feta<br>4 ☐ Pregnant at time of c          | aldeath 3□        | Ectopic pregnancy  |                                |   | Mon                   | of deliver   | Day Year   |
|                | O a a a b a d  | ysi                  | 1 ☐ Yes 2 ☐ No<br>9 ☐ Unknown                                 | 9☐ Unknown  | 36401 3           | Other (specify)  |                                |   |                       |              |  |
|                | 15, P.O.   | 4                    | Part II. Dther significant conditions                         | contributing to death but not re-                             | culting in the    | adorhina oouso ans   | on in Dart I                   | 220 Did toho                            | 200 1100 2001         | buda da dhe  |  |
|                | igne a   | by                   | Tarin Bulling Significant Containing                          | contributing to death but not res                             | saiting in the di | idenying cause give  | en in Paiti.                   |   |                       |              | e cause of death?                                  |
|                | COLD<br>w require<br>been sign   | Completed            |   |   |                   |  |                                | 1 Ves                                   | 2⊌No                  | 3 ☐ Proba    | abiy 4 □Unknown                                    |
|                | Dec<br>e law r<br>has be   | pie                  |   |   |                   |  |                                | 24a. Was an                             | 24b. W                | ere autop    | sy findings available                              |
|                | The The age  | E                    |   |   |                   |  |                                | autopsy<br>performe                     | id? de                | eath?        | _  |
|                | Ettica   | 0                    | 25. Was case referred to medical                              |   |                   |  | OC Place of Death              | 1/2 Yes 2                               |                       | □ Yes 2      | ZIØ No   |
|                | V eich   | 0 8                  | examiner?<br>1 ☐ Yes 2 Ø No                                   | Hospital: 1 Inpatient 2                                       | ER/Outpatien      | Othe   |                                | (Check only one)                        |                       |              |  |
|                | o ff file  | 1: To                | 27. Manner of Death   |   | 28b. Time of      | t 3 DOA  | er: 4 Nursing Ho               | me 5 Hesidena<br>28d. Describe how      |                       |              | )  |
|                | On ding  | tlor                 | 1 Natural 5 Pending   | 28a. Date of Injury<br>(Month, Day Year)                      | Injury            | Work   | k?<br>Yes 2 □No                | 200. 20001.20 1101                      | inquity occurre       | · ·          |  |
|                | VISION Of VITAI RECONDS, P.O. Attending Physicien: The law requires that the de roeath.  ector: Atler this certificate has been signed by the iby the funeral director, page 2 should be detached  | ica                  | 3 Suicide 6 Could not b                                       |   | ama fa :-         |  |                                | 004 1                                   |                       |              |  |
|                | Division of Vital Records, for Attending Physicien: The law requires that death.  Director: Atten this certificate has been signed in by the funeral director, page 2 should be controlled.  | Certification:       | 4 Homicide determined   | 28e. Place of Injury - At h<br>building, etc. (Speci          | fy)               | eet, ractory, office   |                                | 28f. Location (Stre<br>City or Town,    | erand Numbe<br>State) | r or Hural   | Houte Number,                                      |
|                | Dital<br>urs a<br>ura i (  |                      |   |   |                   |  |                                |   |                       |              |  |
|                | Division of Vital Re hospital or Attending Physicien: The Infine 24 hours after death.  o the Funeral Director: After this certificate he ompletely tilled in by the tuneral director, page  | Medical              | Check only 2 Medical Exa                                      | nysician: To the best of my knominer: On the basis of examina | owledge, death    | occurred at the tim  | ne, date and place,            | and due to the caused at the time, date | se(s) and man         | ner as sta   | ated.  |
|                | the I  | led                  | ,   | and manner stated.  |                   |  |                                | unio unio, uate                         | and place, a          | ia and (c)   | are cause(s)                                       |
|                | 0 0 0 5  | 2                    | 29b. Signature and title of certifier                         | /   |                   | 29c. License   | e number                       | 29d                                     | . Date signed         | (Month, D    | Dav. Year)   |

State Registrar

31. Date filed (Month, Day, Year) DEC 2 7 2005

NWANKWO M.D Sinai Hospital

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

RES -000

|              |   |                | For<br>State<br>Registrar   | State of Maryland / [   | Department of F<br>Certificate of                   |   | ntal Hygien  | 000 4   | 1732                                |
|--------------|---|----------------|---|---|---|---|--|---|-------------------------------------|
|              |   |                | Decedent's Name (First, Middle, Last)   |   |   | 2   | Date of Death  |   | 3. Time of Death                    |
|              | Physicia  |                | MADELINE  | VIOLA SM  | T14   |   | Month Da   | ay Year   | 3100 PM                             |
|              | /Medic<br>Examin  |                | 4a. Facility Name (If not institution, give s   |   | 4b. City, Town, o                                   | r Location of Death                                 |  | c. County of Death                                      |                                     |
|              |   |                | CARROLL COUN  | 44 MACREALL   | en BRIT.  | I MORE  |  | CARRO   | 11                                  |
|              | Funeral   |                | Social Security Number     6. Sex   |   | 1   |   | Date of Birth<br>(Month, Day, Year                     |   | lace (State or Foreign              |
|              | Director  |                | 237-38-1833   | M 201 79  | Yrs. Moritis Days                                   | Hours Will.   | MARCH FT.  | 1926  | V.C.                                |
|              | pu >  |                | Usual Residence of Decedent   | 100 City Town   |   |   |  |   |                                     |
|              | anyla<br>shov   | _              | 10a. State 10b. County  | 10c. City, Tow  |   |   |  | 1   | 0d, Inside City Limits              |
|              | 8a-f  | scto           | 111a. N/  | H MAL   | TIMORE  |   |  |   | 1 PYes 2 No                         |
|              | vith th   | Director       | 10e, Street and Number  | 0   | 10f. Zip Code                                       | ,   |  | itizen of What Coun                                     | itry?                               |
|              | hours after death with the Maryland<br>tural; or Items 23a or 28a-f show<br>al Examinar must be notified at   |                | 4301 CELENAR  | m HUE   |   | 206   |  | L.S.A.  |                                     |
|              | er de   | Funerai        |   | <ol> <li>Was Decedent Ever in U.S.<br/>Armed Forces?</li> </ol> | 13. Was Decedent of H<br>If Yes, specify Cuba       | lispanic Origin? (Specif<br>an, Mexican, Puerto Ric | y Yes or No-<br>an, etc.)                              | <ol> <li>14. Race - Americ<br/>Black, White,</li> </ol> |                                     |
| 36           | s aft   | by F           | 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced  | 1 ☐ Yes 2 No<br>If Yes, Give                                    | 1 ☐ Yes 2月 No                                       | Specify:  |  | Specify:  | 2. 1.                               |
| 215-0036     | hour<br>tural   | pa             | 15. Decedent's Educ   | Year or Dates:  | Decedent's Usual Occup                              | action  | 165  | Kind of Business/Inc                                    | YCK                                 |
| <del>1</del> | n 72<br>n "nat  | Completed      | (Specify only highest grade   | completed)  | (Give kind of work done<br>life. DO NOT use retired | during most of working                              | 100.1  | Ciria oi business/inc                                   | dustry                              |
| 212          | within<br>ene.<br>than "  | Ĕ              | Elementary/Secondary (0-12)   | College (1-4or 5+)  | SEAMSTRE  | ·   | 14   | TETU L  | hebee                               |
|              | filed<br>Hygir<br>Sther   |                | 17. Father's Name (First, Middle, Last)   | 77777   |   | 18. Mother's Name (F                                | First, Middle, Maide                                   | n Sumame)   | mount.                              |
| an           | ould be<br>Mental<br>arked c<br>atic eve  | To Be          | WARUMON   | PETTMEN   |   | ETHE  | Por  | noher   |                                     |
| Maryland     | s 1 and 2 should be filed within 72 hours after death with the Marylan I Health and Mental Hyglene. I Health and Mental Hyglene it is the 23 or 28a-1 show item 27 is marked other than "natural", or items 23a or 28a-1 show other traumatic event, the Medical Examinar must be notified at | F              | 19a. Informant's Name/Relationship (Ty)   | pe, Print) 19b  | . Mailing Address (Street                           | and Number or Rural F                               | loute Number, City                                     | or Town, State, Zip                                     | Code)                               |
| Z            | od 2 to lith ar 27 is ritrau  |                | LEE PETTMON   | 150N 4  | 201 /2/01   | Gras ALE  | 17   |   | d. 21206                            |
| e,           | 1 and<br>Health<br>tem 27<br>other tr   |                | 20a. Method of Disposition  | 20b. Place o  | f Disposition (Name of                              | Date  |  | Location - City or To                                   |                                     |
| altimore,    | 8°= 5   |                | 1 Burial 2 Cremation 3 R  | emoval from State   | ry, crematory or other place                        | (8)   | 10- 12   | )<br>   |                                     |
| ₩            |   |                | * 4 □ Donation S □ Other (Specify)  21. Signature of Euneral Service License                                | YTOIK   | 22 Name and Addre                                   | ses of Facility                                     | 103 (1)  | Tous/zu   | e, Md.                              |
| Ba           | permit. Departr Importa any inje  |                |   | 1 page to   | ZA12 121  | ss of Facility                                      | 19 1.  | rome  | tie TIS                             |
|              | _   |                | 23a. Part Enter the disease, or compli  | cations that caused the death. Do                               | not enter the mode of dvir                          | on such as cardiac or r                             | 1 SACTO  | 2. M.   | Approximate                         |
|              |   |                | snock, or heart failure. List only or<br>Immediate Cause (Final   | e cause on each line.   |   | ,   |  |   | Interval Between<br>Onset and Death |
|              | Physician<br>/Medical   |                | disease or condition resulting in death)  | CARDIOTU  |   | FALL  | LRE  |   |                                     |
| п            | Examiner  |                |   | Due to (or as a consequence                                     | · ·   |   |  |   |                                     |
|              |   | er             | Sequentially list conditions,   | Due to (or as a consequence                                     |   |   |  |   |                                     |
| 2,           | ted   | in             | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | (0. 40 4 50.004 50.000  |   |   |  |   |                                     |
| 6            | be executed<br>sician and<br>burial-transit   | Examin         | that initiated events resulting in death) Last  | Due to (or as a consequence                                     | of):  |   |  |   |                                     |
| 8760,        | cate be executed<br>bhysician and<br>the burial-transif   |                |   |   |   |   |  |   |                                     |
| 687          | phy:  | edicai         |   |   |   |   |  |   |                                     |
| Вох          | The law requires that the death certificate has been signed by the attending Islange 2 should be detached for use as  | Physician/Me   | IF FEMALE:<br>23b. Was decedent pregnant  | 3c. If yes, outcome of pregnancy                                |   |   | T ye ya da dana da | 23d. Date of delive                                     | an/                                 |
| ă            | atte<br>atte  | clar           | in the past 12 months?  | 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death    | 3 ☐Ectopic pregnancy 5 ☐ Other (specify)            | /   |  |   | Day Year                            |
| o.           | that the de<br>led by the a<br>detached f   | ıysi           | 1 ☐ Yes 2 ☐ To<br>9 ☐ Unknown   | 9□ Unknown  |   |   |  |   |                                     |
| <u>α</u>     | that<br>ed b  | y P            | Part II. Other significant conditions cor   | tributing to death but not resulting i                          | n the underlying cause giv                          | en in Part I.                                       | 23e. Did tobacco                                       | use contribute to th                                    | ne cause of death?                  |
| sp.          | uires<br>sign<br>ld be  | d by           |   |   |   |   | 1 ☐ Yes 2  | 2 <b>)⊆</b> ĺÑo 3⊟ Prob                                 | ably 4 Dunknown                     |
| <u>o</u>     | w requ  | iete           |   |   |   |   | 24a. Was an  | 24h Wasa auto   | psy findings available              |
| Records,     | The lay   | Completed      |   |   |   |   | autopsy<br>performed?                                  | prior to condeath?                                      | mpletion of cause of                |
| <u>a</u>     |   |                | 25. Was case referred to medical  |   |   |   | 1□ Yes 2XN   | o 1 🗆 Yes   | 2 No                                |
| Vital        |   | o Be           | examiner?   | lospital:   | strations all pos Oth                               | 26. Place of Death (C                               |  |   |                                     |
| o            | Phys<br>raidi   | <b>-</b>       | 1 ☐ Yes 2 No  | 1 Inpatient 2 ER/O₁ 28a. Date of Injury 28b.                    | Itpatient 3 DOA Time of 28c. Injur                  | 4 U Nursing Home                                    | 5   Residence<br>d. Describe how inju                  | 6 ☐Other (Specify                                       | 0                                   |
| no           | ding l<br>h.<br>After<br>funer  | tion           | 1 XNatural 5 ☐ Pending  |   | njury Wor   | rk?<br>Yes 2 □ No                                   | . Describe new mile                                    | ny occurred   |                                     |
| Division     | death<br>ctor:<br>y the   | Certification: | 3 Suicide 6 Could not be  | 28e. Place of Injury - At home, fa                              |   |   | Location (Street a                                     | and Number or Rura                                      | I Route Number                      |
| Θ            | after<br>Dire   | erti           | 4 Homicide  | building, etc. (Specify)  | , otroot, lastery, office                           |   | City or Town, Star                                     | fe)   | , resid riginger,                   |
| _            | To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer  |                | 29a. Certifier 1 Certifying Phys  | sician: To the best of my knowledge                             | e, death occurred at the tir                        | me, date and place, and                             | due to the cause/s                                     | s) and manner as st                                     | rated                               |
|              | 24 h<br>24 h<br>Fur<br>etely  | edicai         | (Check only 2 Medical Examinations)   | ner: On the basis of examination are and manner stated.         | nd/or investigation, in my o                        | ppinion, death occurred                             | at the time, date an                                   | nd place, and due to                                    | the cause(s)                        |
|              | o the   | Me             | 29b. Signature and title of certifier   | )   | 29c. Licens   | se number   | 29d. Da  | ate signed (Month, L                                    | Day, Year)                          |
|              | - > - ō   |                | 1 James   | -eal  | Doo   | 56736   |  | 12-92-  |                                     |
|              |   |                | 30. Name and address of person who co   | moleted cause of death (from 33-1)                              |   |   |  | 0 04  |                                     |
|              | +   |                |   | HEED .  | (+ypo, + iiii)                                      |   |  |   |                                     |
|              | Sta   | ite            | 31. Date filed (Month, Day, Year)   | 22.72   | 1   |   |  |   |                                     |
|              | Regist  |                | DEC 2 7 ZU  | H LA  | park  |   |  |   |                                     |

|            |  |                        | For State   | State of Maryland / Dep  |   | Mental Hygie  | 3enn5 1.1733   |
|------------|--|------------------------|---|--|---|---|--|
|            |  |                        | Registramend TTem  1. Decedent's Name (First, Middle, La.   | <b>18 Per FH G850 12/28</b>  | Tingain of Death  | Reg. 2. Date of Death   | No. 3. Time of Death   |
| 1          | Physici<br>/Medic  | _                      | Evelyn A  | Sm, Th   |   |   | Day Year 12:45 PM  |
|            | Examin   | _                      | 4a. Facility Name (Inot institution, give   |  | 4b. City, Town, or Location of De   | ath   | 4c. County of Death  |
|            | Funeral  |                        | Social Security Number 6. S   | Du oxe   |   | rs. 8. Date of Birth  | 9. Birthplace (State or Foreign  |
|            | Director   | 0                      | Usual Residence of Decedent   | 4 69 Yrs.  | ]   | Nov. 01,1   | 936 Nokith ardina  |
|            | aryland<br>Show  | _                      | 10a. State 10b. County  | 10c. City, Town or L   |   |   | 10d. Inside City Limits  |
|            | 28a-f  | Funeral Director       | 10e, Street and Number  | Balti  | 10f. Zip Code   | 100   | 1 AYes 2 □ No Citizen of What Country?   |
|            | th with  | al DI                  | 1569 Stones   | wood Road  | 21239   | log.  | (1.5A  |
|            | er dea   | uner                   | 11. Marital Status  | 12. Was Decedent Ever in U.S. 13. Armed Forces?  | Was Decedent of Hispanic Origin?<br>If Yes, specify Cuban, Mexican, Pue   | (Specify Yes or No-<br>erto Rican, etc.)  | 14. Race - American Indian,<br>Black, White, etc.  |
| 5-0036     | s 1 and 2 should be filed within 72 hours after death with the Maryland I Health and Mental Hygiene. I Health and Mental Hygiene. I markad othar than "natural", or Itams 23a or 28a-f show feet traumatic avant, the Medical Exertance rules be medified at other traumatic avant, the Medical Exertance rules be medified at | þ                      | 1 Never Married 2 Married  3 Widowed 4 Divorced   | 1 Tes 2 No If Yes, Give Year or Dates:   | 1 ☐ Yes 2 ☐ Yo Specify:   |   | Specify: Black   |
| 15-0       | n 72 h   | letec                  | 15. Decedent's Ed<br>(Specify only highest gra  | ide completed) (Give   | edent's Usual Occupation<br>a kind of work done during most of w<br>DO NOT use retired)   | orking 16b  | . Kind of Business/Industry  |
| 2121       | filed within<br>Hygiene.<br>Ithar than "   | Completed              | Elementary (Secondary (0-12)  | College (1-4or 5+)   | Chers Aid   | e E   | ducation   |
| Maryland   | ould be file<br>Mental Hy<br>arkad oth<br>atic avant   | Be                     | 17. Father's Name (First, Middle, Last)   | 20100  | 18. Mother's N  | ame (First, Middle, Maid  | len Sumame)  |
| aryl       | 2 should<br>and Men<br>is marka  | T <sub>0</sub>         | 19a. Informant's Name/Relationship  | Type, Print) 19b. Maifi  | ing Address (Street and Number or   | Rural Route Number, Cit   | y or Town, State, Zip Code)  |
|            | 1 and 2<br>Health a<br>em 27 is  |                        | Nina Taylo  | oR (Daughter) 181  | 53 BURNWOO  |   | WHO.MD 21239   |
| Baltimore, | 0  |                        | 20a. Method of Disposition  1 Burial 2 □ Cremation 3 □  4 □ Donation 5 □ Other (Specifi   | nemoval moin State   | osition (Name of smallory or other place)   | Date 20c.   | Do I lo A I  |
| altir      | orts<br>inje   |                        | 21. Signature of Funeral Service Licen  | - IUI LU   | 2. Mame and Address of Facility   | 1420/US   | Dato 1910  |
| 8          | Dep<br>Imp   |                        | By Clyti  | 1 mo1363   | 4905 YORK   | rd Balt   | OMD 21212  |
|            | Dhysisian  |                        | Immediate Cause (Final  | plications that caused the death. Do not en one cause on each line.  | ter the mode of dying such as cardi   | ac or respiratory arrest,   | Approximate Interval Between Onset and Death   |
|            | Physician<br>/Medical  |                        | disease or condition resulting in death)  | a. Anoxic /5/.  Due to (or as a consequence of):   | oin thjury  |   | 3 wk   |
|            | Examiner   | 10                     | Sequentially list conditions,   | b. As Mm A  Due to (or as a consequence of):   |   |   |  |
|            | cuted<br>d<br>ansit  | Examiner               | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events | Due to (or as a consequence or).   |   |   |  |
| 90,        | cate be executed<br>physicien and<br>the burial-transit  |                        | resulting in death) Last  | Due to (or as a consequence of):   |   |   |  |
|            |  | edlcal                 | •   | . d  |   |   |  |
| Вох        | death certifi<br>e attending<br>id for use as  | an/M                   | IF FEMALE:<br>23b. Was decedent pregnant  | 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐   | □Ectopic pregnancy  |   | 23d. Date of defivery  |
| .O.        | 0 0 0  | Physician/M            | in the past 12 months? 1 ☐ Yes 2 ▼No 9 ☐ Unknown  |  | Other (specify)   |   | Month Day Year   |
| S, P.      | es that tigned by  | by Ph                  | Part II. Other significant conditions of  | ontributing to death but not resulting in the u  | ınderlying cause given in Part I.   | 23e. Did tobacc   | o use contribute to the cause of death?  |
| ords       | uire<br>sig<br>id b  |                        |   |  |   | 1011  | 2 No 3 Probably 4 Unknown  |
|            | noc  | te                     |   |  |   | 1 ∐ Yes   |  |
| Rec        | ne law require<br>s has been sig<br>ge 2 should b  | mplete                 |   |  |   | 24a. Was an autopsy   | 24b. Were autopsy findings available prior to completion of cause of   |
|            | The la<br>ate has<br>page 2  | se Completed           | 25. Was case referred to medical  |  | 26. Place of D  | 24a. Was an autopsy performed 1 Yes 2 2   | 24b. Were autopsy findings available prior to completion of cause of death?  |
| of Vital   | hysician:<br>his certifica<br>i director, p  | 0                      | examiner?<br>1 Tes 2 No   | Hospital: 1 Manpatient 2 □ ER/Outpatier  | Other   | 24a. Was an autopsy performed   | 24b. Were autopsy findings available prior to completion of cause of death?  1 □ Yes 2 ▼No   |
| of Vital   | hysician:<br>his certifica<br>i director, p  | To Be C                | examiner? 1  Yes 2 No  27. Manner of Death 1 Natural 5 Pending  | 28a. Date of Injury (Month, Day Year)  28b. Time o   | of 28c. Injury at Work?   | 24a. Was an autopsy performed; 1 Yes 2 12   | 24b. Were autopsy findings available prior to completion of cause of death? 1  Yes 2 No 6  Other (Specify)   |
| of Vital   | hysician:<br>his certifica<br>i director, p  | To Be C                | examiner? 1 Tyes 2 No  27. Manner of Death  | 28a. Date of Injury - At home, farm, str   | nt 3 DOA Other: 4 Nursing of 28c. Injury at Work? M 1 Yes 2 No  | 24a. Was an autopsy performed 1 Yes 2 1 1 Yes 2 2 1 1 Yes 2 2 2 1 2 2 2 3 2 3 2 3 2 3 2 3 2 3 3 2 3 3 3 2 3 | 24b. Were autopsy findings available prior to completion of cause of death? 1  Yes   |
| of Vital   | hysician:<br>his certifica<br>i director, p  | Certification: To Be C | examiner?  1  | 28a. Date of Injury (Month, Day Year)  28b. Time of Injury  28b. Place of Injury - At home, farm, stribuilding, etc. (Specify)   | of 28c. Injury at Work?  M 1 Yes 2 No  reet, factory, office  | 24a. Was an autopsy performed; 1 Yes 2 1 1 eath (Check only one)  Home 5 Residence 28d. Describe how in City or Town, Sta                         | 24b. Were autopsy findings available prior to completion of cause of death?  1  Yes 2 No  6  Other (Specify) jury occurred  and Number or Rural Route Number,  |
| of Vital   | hysician:<br>his certifica<br>i director, p  | Certification: To Be C | examiner?  1  | 28a. Date of Injury - At home, farm, str   | ont 3 DOA Other: 4 Nursing of 28c. Injury at Work? M 1 Yes 2 No reet, factory, office   | 24a. Was an autopsy performed/ 1 Yes 2 1 1 1 Yes 2 2 1 1 1 1 2 1 2 1 2 1 2 1 2 1 2 1 2  | 24b. Were autopsy findings available prior to completion of cause of death?  1 Yes 2 No  6 Other (Specify) jury occurred  and Number or Rural Route Number, atte)  |
| of Vital   | hysician:<br>this certifice<br>al director, p  | To Be C                | examiner?  1  | 28a. Date of Injury 28b. Time o Injury (Month, Day Year)  28e. Place of Injury - At home, farm, str building, etc. (Specify)  28ician: To the best of my knowledge, death and magner stated. | of 28c. Injury at Work?  M 28c. Injury at Work?  M 1 Yes 2 No  reet, factory, office  th occurred at the time, date and place investigation, in my opinion, death occurred at the time. | 24a. Was an autopsy performed 1 Yes 2 1 2 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1   | 24b. Were autopsy findings available prior to completion of cause of death?  1  Yes 2 No  6  Other (Specify) jury occurred  and Number or Rural Route Number,  (s) and manner as stated.  Ind place, and due to the cause(s)       |
| of Vital   | To the Hospital or Attanding Physician: within 24 hours after death. To the Funeral Director: After this certifice completely filled in by the funeral director, p   | Certification: To Be C | examiner?  1  | 28a. Date of Injury 28b. Time o Injury (Month, Day Year)  28e. Place of Injury - At home, farm, str building, etc. (Specify)  28ician: To the best of my knowledge, death and magner stated. | of 28c. Injury at Work?  M 28c. Injury at Work?  M 1 Yes 2 No  reet, factory, office  th occurred at the time, date and place investigation, in my opinion, death occurred at the time. | 24a. Was an autopsy performed 1 Yes 2 1 2 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1   | 24b. Were autopsy findings available prior to completion of cause of death?  1  Yes 2 No  6  Other (Specify) jury occurred  and Number or Rural Route Number,  (s) and manner as stated.  Ind place, and due to the cause(s)       |
| of Vital   | hysician:<br>his certifica<br>i director, p  | Certification: To Be C | examiner?  1  | 28a. Date of Injury 28b. Time o Injury (Month, Day Year)  28e. Place of Injury - At home, farm, str building, etc. (Specify)  28ician: To the best of my knowledge, death and magner stated. | of 28c. Injury at Work?  M 28c. Injury at Work?  M 1 Yes 2 No  reet, factory, office  th occurred at the time, date and place investigation, in my opinion, death occurred at the time. | 24a. Was an autopsy performed 1 Yes 2 1 2 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1   | 24b. Were autopsy findings available prior to completion of cause of death?  1  Yes  2  No  6  Other (Specify) jury occurred  and Number or Rural Route Number, atte)  (s) and manner as stated. Indicates and due to the cause(s) |

|   |                     | 1 - For<br>State<br>Registrar   |   | aryland / Depa<br><i>Cei</i>                    | artment of<br>tificate o                                |  |  | Reg. No. UUJ                               | 41734   |
|---|---------------------|---|---|---|---|--|--|--|---|
| Physici   | an                  | Decedent's Name (First, Middle, La  | st)   |   |   |  | 2. Date of De<br>Month                     | Day Yea                                    | 3. Time of Death  |
| /Medic  |                     | Mary  | E.  | Syd   |   |  | 12   | 20 2005                                    | 2141 M  |
| Examir  | er                  | 4a. Facility Name (If not institution, give   | e street and number)  |   | •   | or Location of D                                       | eath                                       | 4c. County of De                           |   |
| - F   | 2000 to             | J.H.H.  | 7.4-  | Market land birth day                           | Ba.<br>If Under 1 Yea                                   | ltimore  | Hrs   0 Data of Bio                        |  | VA  |
| Funeral<br>Director   |                     | 220 20 2220   | I M 2 F 9   | (In yrs. last birthday)  Yrs.                   | Months Day  |  | Min. 8. Date of Bir (Month, Date 1—28      | 8–09                                       | irthplace (State or Foreign<br>Country)<br>Md.                              |
| pug *   |                     | Usual Residence of Decedent  10a. State 10b. County   |   | 10c. City, Town or Lo                           | cation  |  |  |  | 10d. Inside City Limits   |
| faryla  | ō                   |   |   | D 11  |   |  |  |  | YYes 2 No   |
| the N   | ect                 | Md. NA  |   | Balt  | imore   |  |  | 10g. Citizen of What                       | Country?  |
| with a or   | 큡                   |   | Ttwoot  |   |   | 1213   |  | US   | ,   |
| eath  | era                 | 1808 N. Chapel S  | 12. Was Decedent B  | Ever in U.S. 13                                 |   |  | ? (Specify Yes or No                       |  | nerican Indian,   |
| 15-0036 72 hours after death with the Maryland "neturel", or iteme 23a or 28a-f ehow coloral Examinal roughter notilied at        | by Funeral Director | 1 ☐ Never Married 2 ☐ Married   | Armed Forces?<br>1  | 10  | f Yes, specify Ci<br>I □ Yes 2 <b>X</b> N               |  | ? (Specify Yes or No<br>uerto Rican, etc.) | Specific                                   | nite, etc.  |
| 5-0036 72 hours aft netural', or  |                     | 3 Widowed 4 □ Divorced  | Year or Dates:  |   | 4   |  |  |  | Black   |
|   | Completed           | 15. Decedent's E<br>(Specify only highest gr  | ducation<br>ade completed)                                      | (Give   | dent's Usual Occ<br>kind of work dor<br>DO NOT use reti | ne during most of                                      | working                                    | 16b. Kind of Busines                       | s/Industry  |
| within see.   | g.                  | Elementary/Secondary (0-12)   | College (1-4or 5  | +)  | omestic   | •  |  | Other Pe                                   | ople Homes  |
| CA 5 2 2 2  |                     | 8th grade<br>17. Father's Name (First, Middle, Lass   | )   |   | Omescic   |  | Name (First, Middle                        | · · · · · · · · · · · · · · · · · · ·      | opie nomes  |
| d be  | Be                  | Unkn  | ,   |   |   | Unkn   |  | ,    |   |
| Maryland d 2 should be file th and Mental Hy ?7 is marked oth traumatic event   | 2                   | 19a, Informant's Name/Relationship  | Type Print)   | 19h Mailir                                      | ng Address /Stre  |  | r Bural Boute Numb                         | er, City or Town, State                    | Zin Code)   |
| Mary<br>nd 2 sho<br>aith and<br>27 is m   |                     |   |   |   |   |  |  | stown, Pa.                                 | 1.731.3   |
| Heall<br>Heall<br>m 2   |                     | Clayburn Sydnor 20a. Method of Disposition  | Son   | 20b. Place of Dispo                             | sition (Name of   |  | Date                                       | 20c. Location - City                       |   |
| Baltimore, permit. Pages 1 a Department of Hea mportant: If item in y injury or other mice.                                       |                     | 1 ⊠ Burial 2 ☐ Cremation 3 [  |   | cemetery, crei                                  | natory or other p                                       | olace)   | 2-27-05                                    | Laurel                                     |   |
| Itin  |                     | 4 ☐ Donation 5 ☐ Other (Speci   |   | Md. Nat   |   |  | 2-27-05                                    | raurer,                                    |   |
| Baltimol<br>permit. Pages<br>Deportment of<br>Important: If it<br>any njury or o  |                     | 21. Signature of Funeral Service Lice   | wone  | <u>`</u> '                                      | March   | F.H. Eas   | t Balt                                     | imore, Md.<br>E. North                     | 21202<br>Ave.   |
| Physician<br>/Medical<br>Examiner   | Examiner            | 23a. Part1. Enter the disease, or con shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | a. PUL  Due to (or as  b. Due to (or as                         | MUNARY a consequence off: SESTIVE               | Her   | PERTE  |  |  | Interval Between Onset and Death YCA DS                                     |
| 8760, rate be executed physicien and the burial-transit   | dical Exar          | that initiated events<br>resulting in death) Last   | Due to (or as   | MONARY a consequence off                        | to tex  | y DI   | sease                                      |  | Venes.s   |
| the death certific<br>type attending by the attending cached for use as   | by Physician/Medic  | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown   | 23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown | of pregnancy<br>2 Fetal death 3 time of death 5 | Ectopic pregna<br>Other (specify)                       | ncy  |  | 23d. Date of c<br>Month                    | Day Year  |
| ords, Frequires that seen signed in   |                     | Part II. Other significant conditions   | contributing to death b   | ut not resulting in the u                       | nderlying cause   | given in Part I.                                       |  |  | to the cause of death?  Probably 4 Unknown                                  |
| I Rec   | Completed           |   |   |   |   |  | 1 ☐ Yes                                    | psy prior t<br>ormed? death<br>2X No 1 □ Y | autopsy findings available<br>o completion of cause of<br>?<br>es 2 \sum No |
| f Vita<br>ysician:<br>ysician:<br>s certific<br>director,   | Be                  | 25. Was case referred to medical examiner?  | Hospital:   |   |   | Other  | Death (Check only                          |  |   |
| Jing Affe   | tion; To            | 1 ☐ Yes 2 ☐ No  27. Manner of Death  1. Natural 5 ☐ Pending 2 ☐ Accident investigation  | 28a. Date of Inju<br>(Month, Day                                |   | 28c. lr   | other: 4 ☐ Nursii<br>njury at<br>Vork?<br>☐ Yes 2 ☐ No |  | idence 6 Other (S)<br>how injury occurred  | pecify)   |
| Division To the Hospital or Attending within 24 hours after death To the Funeral Director: After completely filled in by the fune | Certification:      | 3 Suicide 6 Could not l<br>4 Homicide determined  |   | ury - At home, farm, str<br>c. (Specify)        | eet, factory, offic                                     | ce   |  | Street and Number or wn, State)            | Rural Route Number,   |
| le Hospital<br>1.24 hours a<br>in Funeral (<br>letely filled  | dical               | (Check only 2 Medical Exa   | miner: On the basis of  | f examination and/or in                         | vestigation, in m                                       | v opinion, death o                                     | occurred at the time.                      | date and place, and d                      | ue to the cause(s)  |
| To th<br>within<br>To th<br>comp  | Me                  | 29b. Signature and title of certifier   | Zan.  | NB  | 29c. Lice   | onse number<br>15480                                   | 2  | 29d. Date signed (Mo                       | nth, Day, Year)   |
| 3   |                     | 30. Name and address of person was all Date filed (Month, Day, Year)  | completed cause of d  | eath (Item 23a) (Type,                          | Print) M  | iclast   | ZIMO                                       | 108,M                                      | D   |
| NAME OF TAXABLE PARTY.  |                     | 31 Date filed (Month Day Vocal  | OPITAL "  | ar's Signature                                  | HORE  | MAI  | CYLAN                                      | 0  |   |
| Sta<br>Regist   | ate<br>rar          | DEC 2 7 20  | 05  | And And   | 180   |  |  |  |   |

DHMH 17 Rev 1/2001

ORIGINAL

MR#M800361093 rimmens, Joseph

20/10/05

State Registrar

Medical

29a. Certifier

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

7 2005

DHMH 17 Rev 1/2001

2

To the Hospital within 24 hours at To the Funarat D

. Registrar's Signature

2336

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M . 0

YOUR

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

021809

INLONIUM MD

29d. Date signed (Month, Day, Year)

DECEMBER 25, ZOOS

|                     |   |                |  | artment of Health and Menta  | 0000 1 1 1 1 10 0 0  |
|---------------------|---|----------------|--|--|--|
|                     |   |                | Registrar  1. Decedent's Name (First, Middle, Last)  | rtificate of Death   | e of Death 3. Time of Death  |
| ı                   | Physici   |                | Roger Lee Steelman   | Mor  | nth Day Year   |
| }                   | /Medic<br>Examin  |                | 4a. Facility Name (If not institution, give street and number)   | 4b. City, Town, or Location of Death   | cember 20, 2005   12:35 P M   4c. County of Death                                    |
|                     | LXumiii   |                | Harford Memorial Hospital  | Havre de Grace   | Harford  |
|                     | Funeral   |                | 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)  | If Under 1 Year If Under 24 Hrs. 8. Date   | e of Birth nth, Day, Year)  9. Birthplace (State or Foreign Country)                 |
| n                   | Director  |                | 220-50-3408 <sup>1</sup> ⊠ M <sup>2</sup> □ F 55 Yrs.  |  | y 11,1950 Maryland   |
|                     | and w   |                | Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Lo  | ocation  | 10d. Inside City Limits  |
|                     | Maryl<br>f sho  | ō              |  |  | 1 ☐ Yes 2 🔯 No   |
|                     | 1 the   | Director       | Maryland Harford Churchy 10e. Street and Number  | 10f. Zip Code  | 10g. Citizen of What Country?  |
|                     | h with  | ai D           | 3144 Aldino Road   | 21028  | USA  |
|                     | ems 3   | Funeral        | 11. Marital Status 12. Was Decedent Ever in U.S. 13. Armed Forces?   | Was Decedent of Hispanic Origin? (Specify Yes<br>If Yes, specify Cuban, Mexican, Puerto Rican, e     | s or No- 14. Race - American Indian,   |
| 9                   | or It   | y Fu           | 1 Never Married 2X Married 1 Yes 2 No  | 1 ☐ Yes 252 No Specify:  | Black, White, etc.  Specify:   |
| Ö                   | hours<br>tural  | ed by          | 3 U Vidowed 4 Divorced Year or Dates:  |  | White  |
| 5                   | within 72 hours after death with the Maryland<br>ane.<br>than "natural", or Items 23s or 28s-f show<br>the Medical Examer must be notified at   | Completed      | (Specify only highest grade completed) (Give   | dent's Usual Occupation kind of work done during most of working DO NOT use retired)                 | 16b. Kind of Business/Industry   |
| 2                   | d with<br>giene.  | E O            | Elementary/Secondary (0-12) College (1-4or 5+)   | enter / Self Employed  | Carpentry  |
| 힏                   | at Hyg<br>othe  | BeC            | 17. Father's Name (First, Middle, Last)  | 18. Mother's Name (First,  |  |
| Jai                 | Menta   | To             | Eugene Fletcher Steelman   | Oda Rose   | Edwards  |
| Maryland 21215-0036 | 12 should be filled within<br>h and Mental Hygiene.<br>7 Is marked other than "<br>traumatic event, the Men   |                | 19a. Informant's Name/Relationship (Type, Print) 19b. Maili  | ng Address (Street and Number or Rural Route   | Number, City or Town, State, Zip Code)   |
|                     | 1 and<br>Health<br>em 27<br>ther tr   |                | Peggy Steelman / Wife 1309   | Lobelia Lane, Belcam   |  |
| Baltimore,          | permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, Item Medical Examatic attended to once. |                | 1 Spurial 2 Communion 3 Chemoval non State   | osition (Name of Date natory or other place)   | 20c. Location - City or Town, State  |
| ≣                   | it. Pa<br>rtmer<br>rtant<br>njury   | l.             |  | lemorial Grdns 12-23-0   |  |
| Ba                  | permit. Departn Imports any inju  |                | Manual Control of the second o | Name and Address of Facility Home,   |  |
|                     |   |                | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter shock, or hear failure. List only one cause of entering the death.  | 317 Cokesbury Road, A er the mode of dying, such as cardiac or respira                               | bingdon, Maryland 21009  Approximate   |
|                     | Physician   |                | Immediate Cause (Final   | 2-P. All.  | Interval Between<br>Onset and Death  |
|                     | /Medical  |                | disease or condition resulting in death)  a  | NI MIJOHNIA  |  |
|                     | Examiner  |                | Sequentially list conditions b Septicember   |  |  |
| 1/                  | ס י≅  | iner           | Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury  |  |  |
| 4                   | ecute<br>and<br>-trans  | Examiner       | Cause (Disease or Injury that initiated events resulting in death) Last C. Due to (or as a consequence of):  |  |  |
| 8760,               | The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit  | aiE            | bue to (of as a consequence of).   |  |  |
| 687                 | ficate<br>physics the   | edicai         | d.   |  |  |
| Вох                 | that the death certific<br>ed by the attending p<br>detached for use as   | Physician/Me   | IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy  |  | 23d. Date of delivery  |
|                     | death<br>e atte   | icia           | 1 Ves 2 No 4 Pregnant at time of death 5   | Ectopic pregnancy Other (specify)  | Month Day Year   |
| P.0                 | at the<br>by the  | hys            | 9 □ Unknown 9□ Unknown   |  |  |
| Ś                   | res that<br>signed b  | þ              | Part II. Other significant conditions contributing to death but not resulting in the u   | nderlying cause given in Part I. 23e   | Did tobacco use contribute to the cause of death?                                    |
| orc                 | w requir<br>been si<br>should   | eted           |  |  | 1 Yes 2 No 3 Probably 4 Unknown  |
| Record              | e law<br>has t  | ompieted       |  | 24a  | a. Was an autopsy findings available prior to completion of cause of                 |
|                     |   | O              | 05.00  |  | performed?   death?<br>Yes 2 □ No 1 □ Yes 2 □ No                                     |
| Vita                | ysician: The is certificate hadirector, page  | o Be           | 25. Was case referred to medical examiner?  1   Yes 2   No   | 26. Place of Death   Check   |  |
| Division of         | g Phys<br>er this<br>eral di  | n: To          | 27. Manney of Death 28a. Date of Injury 28b. Time of   | 4 Nursing Home 5   | Residence 6 Other (Specify) scribe how injury occurred                               |
| 0                   | ttendin<br>death.<br>stor: Aft<br>/ the fun   | atio           | 1 V  | M 1 Yes 2 No   |  |
| Σ                   | after de<br>Directo   | Certification: | 3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of Injury - At home, farm, str building, etc. (Specify)  | eet, factory, office 28f. Loca   | ation (Street and Number or Rural Route Number, or Town, State)                      |
| Ω                   | oital o<br>urs af<br>oral D   |                |  |  | ,  |
|                     | To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certifica completely filled in by the funeral director.   | Medical        | 29a. Certifier  (Check only one)  Certifying Physicien: To the best of my knowledge, death (Check only one)  2□ Medical Examiner: On the basis of examination and/or in and manner stated.   | n occurred at the time, date and place, and due<br>vestigation, in my opinion, death occurred at the | to the cause(s) and manner as stated.  time, date and place, and due to the cause(s) |
|                     | To the within To the Comple   | Me             | 29b. Signature and title of certifier  | 29c. License number / )  | 29d. Date signed (Month, Day, Year)  |
| )                   | - > - ō   |                | I & L. M.D.  | 720661   | 12/2/10+   |
|                     | 1   |                | 30. Name and address of person who completed pause of death (Item 23a) (Type,  | Print) / AA  |  |
|                     | כן  |                | J. T. LeeM.D. 669 KOUDLUI  | Ton St. Havre  | de Grace MD  |
|                     | Sta<br>Registr  |                | 31. Date filed (Month, Day/Year)  DEC 2 7 2005   |  | 2/078  |
|                     | riogisti  |                | The same of the sa |  | - 1 - 10   |

|                            |  |                 | For State Registrar  | State of Ma                                | ıryland                    |                                | artmen<br>tificat                     |                          |                                | nd Mer                    |                          | giene       | 105                       | 4173  | 37               |
|----------------------------|--|-----------------|--|--|----------------------------|--------------------------------|---------------------------------------|--------------------------|--------------------------------|---------------------------|--------------------------|-------------|---------------------------|---|------------------|
| 10.75                      | · (E)  |                 | 1. Decedent's Name (First, Middle, Las   | st)  |                            |                                |                                       |                          |                                | 2.                        | Date of De               | aath<br>Day | Yea                       | 3. Time of                                  | Death            |
|                            | Physicia<br>/Medic   |                 | Everett  | L. Smith                                   |                            |                                |                                       |                          |                                | De                        |                          |             | , 2005                    |   | A M              |
|                            | Examin   | A               | 4a. Facility Name (If not institution, give  | street and number)                         |                            |                                | 4b. City,                             | Town, or                 | Location of [                  | Death                     |                          | 4c.         | County of De              | ath   |                  |
|                            |  | ić.             | Calvert Memorial   | Hospital                                   | (1-,                       | man telephone il               | Pri                                   | ince                     | Frede                          | rick                      | Data of Riv              | C           | alvert                    | light 1 (Ot - t -                           | - Ci             |
|                            | Funeral  |                 | 5. Social Security Number 6. S   | KIM 2 DE                                   | 66 (in yrs. ii             | ast birthday)<br>Yrs.          | Months                                |                          |                                | Min.                      | (Month, Da               | y, Year)    | 1030 N                    | Sirthplace (State of<br>Country)<br>ew York | r Foreign        |
|                            | Director   | }               | Usual Residence of Decedent  |  | 00                         |                                |                                       |                          |                                | Au                        | gust                     | 20,         | I J J N                   | ew TOLK                                     |                  |
|                            | yland  |                 | 10a. State 10b. County   |  | 10c. City                  | , Town or Lo                   | cation                                |                          |                                |                           |                          |             |                           | 10d. Inside C                               | 1                |
|                            | r the Marylan  | ë i             | Maryland Calvert   |  | Hu                         | ntingt                         | own                                   |                          |                                |                           |                          |             |                           | 1 🗆 Yes                                     | 2 <del>∏</del> № |
|                            | or 28  | Slre.           | 10e. Street and Number   |  |                            |                                | 10f. Zip                              | Code                     |                                |                           |                          | 10g. Citi   | zen of What               | Country?                                    |                  |
|                            | hours after death with the Maryland<br>tural; or Itams 23a or 28a-f ehow<br>al Ezamanat must be collified at   | Funeral Directo | 4042 Birch Drive   |  |                            |                                |                                       | 206                      |                                |                           |                          |             | U.S.A.                    |   |                  |
|                            | ar deg   | une             | 11. Marital Status   | 12. Was Decedent E<br>Armed Forces?        |                            | S. 13.                         | Was Dece<br>If Yes, spe               | dent of Hi<br>cify Cuba  | spanic Origin<br>n, Mexican, F | n? (Specify<br>Puerto Ric | / Yes or No<br>an, etc.) | p-          | 14. Race - Ar<br>Black, W | merican Indian,<br>hite, etc.               |                  |
| 30                         | rs aft   | by F            | 1 ☐ Never Married 2X Married 3 ☐ Widowed 4 ☐ Divorced                                | 1 ☐ Yes 2X N If Yes, Give Year or Dates: 1 |                            | 61                             | 1 🗌 Yes                               | 2 <b>)</b> No            | Specify:                       |                           |                          |             | Specify: p                | lack  |                  |
| 9500-61212                 | be filed within 72 hours after death with Hydison. d other than "natural", or Itams 23e or event, the Mudical Examiner must be.  |                 | 15. Decedent's Ed  | ducation                                   | 937-                       | 16a. Dece                      | dent's Usu                            | al Occupa                | ation                          |                           |                          | 16b. Ki     | nd of Busines             |   |                  |
| 212                        | within 72<br>ene.<br>then "net<br>he Madic   | Completed       | (Specify only highest gra  | ade completed)  College (1-4or 5-          | ٠,                         | (Give<br>life.                 | kind of wo<br>DO NOT u                | ork done d<br>se retired | luring most o<br>)             | f working                 |                          |             |                           | ,   |                  |
| 717                        | d with   | E O             | Elementary/Secondary (0-12)  | 4  | */                         | Vic                            | e Pre                                 | eside                    | ent                            |                           |                          | Reco        | rding                     | Industry                                    | 7                |
|                            | be filed within tal Hygiene. d other than "  | Be C            | 17. Father's Name (First, Middle, Last)  | )  |                            |                                |                                       |                          | 18. Mother's                   | Name (F                   | irst, Middle             | , Maiden    | Sumame)                   |   |                  |
| yland                      |  | To              | Everett E. Sm  | ith  |                            |                                |                                       |                          | Ma                             | abe1                      | Wilke                    | rson        |                           |   |                  |
| Mar                        | 2 shoul<br>and Ma<br>ie mari<br>aumati   | i               | 19a. Informant's Name/Relationship (   | Type, Print)                               |                            | 19b. Maili                     | ng Address                            | s (Street a              | and Number                     | or Rural R                | oute Numb                | er, City o  | r Town, State             | , Zip Code)                                 |                  |
|                            | s 1 and 2 should<br>f Health and Mer<br>fam 27 ie marka<br>other traumatic   |                 | Dr. Velma Smith/W  | ife  | 1001 101                   |                                |                                       |                          | . Hunt                         |                           |                          |             |                           |   |                  |
| o<br>E                     | 0 0 = =  |                 | 20a. Method of Disposition  12 Burial 2 Cremation 3                                  | Removal from State                         | 206. P                     | lace of Dispo<br>emetery, crei | natory or o                           | me or<br>other plac      | 9)                             | Date                      |                          | 20c. Lo     | cation - City             | or Town, State                              |                  |
| Baltimore,                 | nit. Pag<br>sartment<br>sortant:<br>injury c   |                 | 4 Donation 5 Other (Specif   |  | For                        | t Line                         | oln (                                 | Cemet                    | ery 12                         | 2/30/                     | 2005                     | Bre         | ntwood<br>uneral          | , MD  |                  |
| g                          | Separ<br>Thoor<br>Thy in   |                 | 21. Signature of Funeral Service Liger   | 3/1/1                                      |                            |                                |                                       |                          |                                |                           |                          |             |                           |   |                  |
|                            | an = a   |                 | 23a Pag1. Enter the disease, or com  | HU   | the doct                   |                                |                                       |                          |                                |                           |                          |             | , MD 2                    | 0/22<br>Approximat                          | -                |
| . [                        | Physician  |                 | shock, or heart failure. List only<br>Immediate Cause (Final<br>disease or condition | one cause on each line                     | 18.<br>Se                  | epsis                          | er the mot                            | 38 Of Cylin              | y, such as ca                  | irdiac or re              | зрпатогу а               | irrest,     |                           | Interval Bet<br>Onset and                   | ween             |
|                            | /Medical<br>Examiner   |                 | resulting in death)  | Due to (or as a                            | a consequ                  | uence of):                     |                                       |                          |                                | -                         |                          |             |                           |   |                  |
| Ά,                         | LAGITITICI   | _               | Sequentially list conditions, if any, leading to immediate                           | b. Due to (or as a                         | Am                         | + e                            | 600                                   | 01891                    | 07                             | Fai                       | 100                      |             |                           |   |                  |
|                            | ed<br>sit  | ulne            | cause. Enter Underlying Cause (Disease or injury                                     | Due to (or as a                            | a consequ                  | A o d                          |                                       |                          | , 0                            |                           |                          |             |                           |   |                  |
|                            | ate be executed<br>nysician end<br>he burial-transit   | Examlner        | that initiated events<br>resulting in death) Last                                    | C. Due to (or as a                         | a consequ                  | uence of):                     |                                       |                          | lon                            | 4                         | 1 LEN                    |             |                           |   |                  |
| 09/                        | sician<br>buria  | calE            |  | 8.4  | Di                         | abete                          | 1                                     |                          |                                |                           |                          |             |                           |   |                  |
|                            | ficate<br>g phys   | =               |  | _ d.                                       |                            |                                |                                       |                          |                                |                           |                          |             |                           |   |                  |
| X                          | nding<br>use a   | Physiclan/Med   | IF FEMALE:<br>23b. Was decedent pregnant   | 23c. If yes, outcome of                    |                            |                                | 7=:                                   |                          |                                |                           |                          |             | 23d. Date of c            | delivery                                    |                  |
| . Box                      | death<br>e atte<br>d for   | icla            | in the past 12 months?<br>1 ☐ Yes 2 ☐ No   | 1☐Live birth 4☐Pregnant at                 |                            |                                | ]Ectopic p<br>] Other (s <sub>f</sub> |                          |                                |                           |                          |             | Month                     | Day   | Year             |
| 0                          | t the<br>by the  | hys             | 9 🗆 Unknown  | 9 Unknown                                  |                            |                                |                                       |                          |                                |                           |                          |             |                           |   |                  |
| ດົ                         | ss tha<br>gned<br>se de  | by P            | Part II. Dther significant conditions of   | _  | ut not resu                | ulting in the u                | nderlying (                           | cause give               | en in Part I.                  |                           |                          |             |                           | to the cause of c                           | /                |
| ğ                          | en sig   |                 | <i>F</i> \   | nemia                                      |                            |                                |                                       |                          |                                |                           | 1 🗆                      | Yes 2       | □ No 3 □                  | Probably 4                                  | Jnknown          |
| ၁၁                         | law re<br>as be<br>2 sho   | ple             | Acute  | Tenal                                      | -                          | ailun                          |                                       |                          |                                |                           | 24a Was                  |             | 24b. Were                 | autopsy findings<br>o completion of c       | available        |
| Division of Vital Records, | The<br>ete h<br>page   | Completed       |  |  | t                          | }                              |                                       |                          |                                |                           | perfo                    | 2 No        | death                     | ?   |                  |
| Ita                        | cian:<br>artific<br>ictor,   | Be (            | 25. Was case referred to medical examiner?   |  |                            |                                |                                       |                          | 26. Place o                    |                           |                          |             |                           |   |                  |
| <u>~</u>                   | hyaic<br>his ca<br>il dire   | ဥ               | 1 ☐ Yes 2 ☑ No   |  |                            | ER/Outpatie                    |                                       | OA Othe                  | er: 4 □ Nurs                   |                           |                          |             | 6 □Other (S)              | pecify)                                     |                  |
| <u>_</u>                   | Ing P  | 6               | 27. Manner of Death 1 ☑ Natural 5 ☐ Pending  | 28a. Date of Injur<br>(Month, Day          | Year)                      | 28b. Time o<br>Injury          |                                       | 28c. Injun<br>Work       |                                |                           | . Describe               | how injur   | y occurred                |   |                  |
| <u>s</u>                   | tendi<br>leath<br>tor: /<br>the fi   | cat             | 2 Accident investigatio 3 Suicide 6 Could not b                                      |  |                            |                                | М                                     |                          | Yes 2□No                       |                           | 1 1 1                    | /C+         | 4.86                      | 0   |                  |
| $\leq$                     | or At<br>fter d<br>Direct<br>in by   | Certification:  | 4 Homicide determined  |  | iry - At no<br>c. (Specify | ome, farm, st                  | reet, factor                          | y, office                |                                | 281                       | City or To               |             |                           | Rural Route Num                             | ber,             |
|                            | To the Hospitel or Attending Physician: The law requires that the death certifica within 24 hours after death.  To the Funerel Director: After this certificate has been signed by the attending phycompletely filled in by the funeral director, page 2 should be detached for use as the |                 | 29a. Certifier Certifying Pt   | hysician: To the best of                   | of my kee                  | wledge door                    | h occurred                            | at the ti-               | e date and                     | nlace and                 | due to the               | Callec(e)   | and manner                | as stated                                   |                  |
|                            | Hos<br>24 hc<br>Fun<br>stely i   | Medical         | (Check only 2 Medical Examone)   | miner: On the basis of<br>and manner sta   | examinal                   | tion and/or in                 | vestigation                           | n, in my op              | oinion, death                  | occurred                  | at the time,             | date and    | place, and d              | ue to the cause(s                           | ;)               |
|                            | o the  | Me              | 29b. Signature and title of certifier  |  |                            |                                | 29                                    | c. License               | e number                       |                           |                          | 29d. Dat    | e signed (Mo              | inth, Day, Year)                            |                  |
|                            | ->-0   |                 | > 3 Show   | MD   |                            |                                |                                       | DS                       | 0290                           |                           |                          | 12          | - 21-                     | 05  |                  |
|                            | NX1  |                 | 30. Name and address of person who   |  | eath (Item                 | 1 23a) (Type,                  | Print)                                | ^                        |                                |                           |                          |             |                           |   |                  |
|                            | 4,   |                 | DhiRen Sh  | 1 110                                      | Ho                         | ED R                           | 7                                     | Proi                     | n4                             | tre                       | desid                    | h           | MD                        | 2067  | 8                |
| 133                        | Sta  |                 | 31. Date filed (Month, Day, Year)  | 37 Registra                                | ar's Signa                 | ture                           | il.                                   | _                        |                                |                           |                          |             |                           |   |                  |
|                            | Registr  | ar              | DEC 2 7 200  | JO CO                                      | 1 18                       | . A                            | ME !                                  |                          |                                |                           |                          |             |                           |   |                  |

|                        |  |                | 1 - For<br>State<br>Registrar  | State of Ma  | ryland /              |                       | rtment                             |                          |                           | and M                   | F   | Reg. No.                    | 05                                  | 41738   |
|------------------------|--|----------------|--|--|-----------------------|-----------------------|------------------------------------|--------------------------|---------------------------|-------------------------|---|-----------------------------|-------------------------------------|---|
| ı                      | Physici<br>/Medic  |                | 1. Decedent's Name (First, Middle, La<br>Gerald Lee St   |  |                       |                       |                                    |                          |                           |                         | 2. Date of Dea<br>Month<br>DECEMB         |                             | , 2ŎŐ5                              | 3. Time of Death 7:28P. M   |
|                        | Examin   | er             | 4a. Facility Name (If not institution, gi  |  | AD.                   |                       |                                    |                          | Location o                | f Death                 |   | 4c. Coi                     | inty of Death                       |   |
| I                      | Funeral<br>Director  |                |  | Sex 7. Age<br>157 M 2□ F 56  | (In yrs. last bi      | irthday)<br>Yrs.      | If Under<br>Months                 | 1 Year<br>Days           | If Under 2<br>Hours       | Min,                    | 8. Date of Birtl<br>(Month, Day<br>Oct 14 |                             | 9. Birth<br>Cou<br>VA               | place (State or Foreign<br>intry)   |
|                        | aryland<br>ehow  | 2              | Usual Residence of Decedent  10a. State 10b. County  Md Carrol1  |  | 10c. City, Tow        |                       |                                    |                          |                           |                         |   |                             |                                     | 10d. Inside City Limits   |
|                        | ith the M<br>or 28e-f  | Director       | 10e. Street and Number<br>2790 Rachele Cou   | rt   |                       |                       | 10f. Zip                           |                          |                           |                         |   | 10g. Citizen                | of What Cou                         | 1 ☐ Yes 2 🛣 No intry?   |
|                        | be filed within 72 hours after death with the Maryland tial Hygiene. of other then "naturel", or Itame 23a or 28e-1 ehow event, the Medical Examinat must be notified at | Funeral        | 11. Marital Status  1 □ Never Married 2 ☒ Married  | 12. Was Decedent E<br>Armed Forces?                                  |                       | 13. V                 |                                    |                          | spanic Orig<br>i, Mexican | gin? (Spe<br>, Puerto F | cify Yes or No-<br>Rican, etc.)           |                             | USA<br>Race - Ameri<br>Black, White |   |
| 215-0036               | hours aft  | þ              | 3 ☐ Widowed 4 ☐ Divorced   | 1 ☐ Yes 2 ☐ N<br>If Yes, Give X<br>Year or Dates:                    |                       |                       | ☐ Yes 2                            | A                        | Specify:                  |                         |   |                             | ecify: who                          | ite   |
| 21215                  | l within 72<br>iene.<br>r then "ne<br>the Medic  | Be Completed   | (Specify only highest given the secondary (0-12) 12  | ade completed)  College (1-4or 5-                                    |                       | (Give i               | kind of work<br>DO NOT us<br>pervi | k done di<br>e retired)  | uring most                |                         | rg  |                             | Manag                               | · ·   |
| Baltimore, Maryland 21 | is 1 end 2 should be filed vor Heelth and Mental Hygie Item 27 is marked other to other treumatic event,   | To Be C        | 17. Father's Name (First, Middle, Las<br>Elmer Strosnider  | r)   |                       |                       |                                    | 1                        | 18. Mothe<br>Beati        |                         | (First, Middle,<br>Clem                   | Maiden Sur                  | name)                               |   |
| Mary                   | end 2 should<br>selth and Men<br>n 27 is marke<br>ier treumatic  |                | 19a. Informant's Name/Relationship<br>Cherie Strosnide   |  |                       |                       |                                    |                          |                           |                         | Route Number                              |                             |                                     | p Code)   |
| more                   | 0 0  |                | 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 [ 4 ☐ Donation 5 ☐ Other (Spec   |  | 20b. Place of cemete. |                       |                                    |                          |                           |                         | ate<br>-05                                |                             | on - City or T                      |   |
| Balti                  | permit. Pag<br>Department<br>Importent: I<br>eny Injury o  |                | 21. Signature of Funeral Service Lice  |  | *                     | 22                    | . Name and                         | d Address                | of Facility               | , Hai                   | ght Fur                                   | neral                       | Home 8                              | Chapel  |
|                        | Physician  |                | 23a. Part1. Enter the disease, or cor<br>shock, or heart failure. List only<br>Immediate Cause (Final                                | one cause on each iin  | θ.                    | not ente              | er the mode                        | of dying                 |                           |                         |   |                             |                                     | Approximate<br>Interval Between<br>Onset and Death  |
|                        | /Medical<br>Examiner   |                | disease or condition resulting in death)   | Due to (or as a  | consequence           |                       | Dicie                              | 3                        | <u> </u>                  |                         |   |                             |                                     |   |
| /                      | cuted<br>nd<br>ransit  | Examiner       | Sequentially list conditions, if any, leading of introdiction cause. Enter Underlying Cause (Disease or injury that initiated events | Due to (or as a  | consequence           | of):                  |                                    |                          |                           |                         |   |                             |                                     |   |
| 3760,                  | cate be executed<br>obysicien and<br>the burial-transit  | dical Ex       | resulting in death) Last   | Due to (or as a  | consequence           | of):                  |                                    |                          |                           |                         |   |                             |                                     |   |
| O. Box 68              | ding l   | Physician/Med  | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  | 23c. If yes, outcome of 1 Live birth 2 4 Pregnant at 9 Unknown       | Fetal death           |                       | Ectopic pre<br>Other (spe          |                          |                           |                         |   | 23d.                        | Date of deliv<br>Month              | ery<br>Day Year   |
| ı                      | sign<br>d be   | Ď              | Part II. Other significant conditions  | contributing to death bu   | t not resulting       | in the un             | derlying ca                        | use giver                | n in Part I.              |                         | 23e. Did to                               | -/                          |                                     | he cause of death?  |
| Vital Records,         | The<br>ete h<br>page   | Completed      | -  | · · · · · · · · · · · · · · · · · · ·                                |                       |                       | L = 84 · · ·                       |                          |                           |                         | 24a. Was a autop: perfor                  | sy                          | prior to co                         | opsy findings available impletion of cause of   |
|                        | Attending Physicien: Ir death. octor: After this certificel by the funeral director, p   | To Be          | 25. Was case referred to medical examiner?  1 XYes 2 No  | Hospital: 1 ☐ Inpatier   | nt 2□EB/O             | utnation              | 1 3□ DO                            | Othor                    |                           |                         | Check only or                             |                             | 0.5 (0.                             | . SCENE   |
| n ot                   | Jing Phy<br>J.<br>After thi<br>funeral c   |                | 27. Manner of Death 1 Natural 5 Pending  | 28a. Date of Injun<br>(Month, Day                                    | /. 28b.               | Time of<br>Injury     |                                    | 3c. Injury               | at                        | 2                       | 8d. Describe h                            | ow injury oc                | curred                              |   |
| DIVISION               | Attendi<br>death.<br>octor: A<br>by the fu   | Certification: | 2 Accident investigation 3 Suicide 6 Could not lead to determine   | 28e. Place of Inju   | ry - At home, fa      | 123<br>arm, stre      | M eet, factory.                    | 1 🗆 Y                    | es 2 📉                    |                         |   |                             |                                     | SY CAL ELECTED  al Route Number, and  |
| á                      | To the Hospital or Attendi<br>within 24 hours after death.<br>To the Funeral Director: A<br>completely filled in by the fu   |                | 4   Horricae   | building, etc.   | Way                   |                       |                                    |                          |                           | R                       | THO PLE                                   | n, State)<br>NS AUVA        | wyro                                | WESTHINSTER   |
|                        | To the Hospital or<br>within 24 hours effe<br>To the Funeral Dir<br>completely filled in   | edical         | 29a. Certifier 1 ☐ Certifying P (Check only one)  1 ☐ Certifying P  2 ☐ Medicaf Exa  | hysician: To the best o<br>miner: On the basis of<br>and manner stat | examination ar        | e, death<br>nd/or inv | occurred a<br>estigation,          | it the time<br>in my opi | e, date and<br>nion, deat | d place, a<br>h occurre | nd due to the o<br>d at the time, o       | ause(s) and<br>late and pla | manner as s<br>ce, and due t        | stated.<br>o the cause(s)   |
| •                      | To t<br>With<br>To t   | Σ              | 29b. Sign ture and title of certifier  | M. 46  | . D D B I             | w                     | 100                                | License                  |                           |                         |   |                             | ned <i>(Month,</i><br>IR 24,2       |   |
|                        | 12   |                | 30. Name and address of person who   | A 1/   |                       | (Type, F              | Print)                             |                          | -                         |                         |   |                             |                                     | TEACH TO SERVICE STATE OF THE |
|                        | Sta  | te             | 31. Date filed (Month, Day, Year)  | P. Registra  | r's Signature         | _1                    | 11 PE                              | INN S                    | TREE                      | T BAI                   | TIMORE                                    | MARYI                       | AND 21                              | 1201  |
|                        | Registr  | ar             | DEC 2 7 200  | ) Herrisa  | N. K                  | 1004                  | K                                  |                          |                           |                         |   |                             |                                     |   |

SUHOMLIN

|                            |  | Í              | State of Maryland / Dep<br>1- State<br>Registra/Amend Item #5 Per FH G851 1/9/8  |   | Reg. I   | £ 005 41739   |
|----------------------------|--|----------------|--|---|--|---|
| *                          | Physici<br>/Medic  |                | 1. Decedent's Name (First, Middle, Last)  DMITRY SUHOMLIN  |   | 2. Date of Death Month December  | 24 2005 8 25 PM   |
| 4                          | Examin   |                | 4a. Facility Name (If not institution, give street and number)  GOOD SAMALITAN HOSPITAL  | 4b. City, Town, or Location of Death BALTINORE                                      |  | 4c. County of Death N/A   |
|                            | Funeral<br>Director  |                | 5. Social Security Number 5 6. Sex 17. Age (In yrs. last birthday 2 F 81 Yrs.  | If Under 1 Year   If Under 24 Hrs.   Months   Days   Hours   Min.                   | (Month, Day, Yea   | 9. Birthplace (State or Foreign Country) 1924 UKRAINE               |
|                            | ryland<br>how  |                | Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or L   | ocation   |  | 10d. Inside City Limits   |
|                            | 88-fs  | Director       |  | CIMORE  |  | 1X Yes 2 No   |
|                            | with the   |                | 10e. Street and Number   | 10f. Zip Code   | 10g. (   | Citizen of What Country?  |
|                            | ns 23  | Funeral        | 2421 KENTUCKY AVENUE           11. Marital Status         12. Was Decedent Ever in U.S.         13.  | 21213  Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto | pecify Yes or No-  | U.S.A.  14. Race - American Indian,                                 |
| 036                        | be filed within 72 hours after death with the Maryland stal Hygiene.  ed other then "natural", or Items 23a or 28a-f show event, the Modified Examinat must be notified at   | by             | Armed Forces?  1 ☐ Never Married 2 ☐ Married   | If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 ☐ No Specify:                      | o Rićan, etc.)   | Black, White, etc.  Specify: WHITE                                  |
| Maryland 21215-0036        | 72 ho  | Completed      | 15. Decedent's Education 16a. Dece<br>(Specify only highest grade completed) (Giv  | edent's Usual Occupation  | king 16b.  | . Kind of Business/Industry   |
| 2                          | han "  | mple           | Elementary/Secondary (0-12) College (1-4or 5+)   | e kind of work done during most of work<br>DO NOT use retired)                      |  | TE BURE OVER  |
| 2                          | Hygie<br>Hygie<br>other t  |                | 1 2 HC   | DUSING  18. Mother's Name   | ne (First, Middle, Maid  | ELF EMPLOYED for Sumame)  |
| lau                        | id be<br>ental<br>ked o  | To Be          | IVAN SUHOMLIN  | ZINA K  | ARNAWUSHE  | ENKO  |
| ary                        | 2 should be and Mental is marked eumatic ev  | H              |  | ing Address (Street and Number or Ru  |  |   |
|                            | and 2<br>ealth a<br>m 27 ii  |                |  | KENTUCKY AVENU  | The state of the s |   |
| Baltimore,                 | of H   |                | 1 X Burial 2 I Gremation 3 I Bernoval from State   | position (Name of smallory or other place)  DREW S CEMETERY                         | 13   | Location - City or Town, State  5. BALTTIMORE: MD                   |
| Ħ                          | 그 문 변 글 .  |                |  | 22 Name and Address of Eachity  |  |   |
| ä                          | Depermine Deperm |                | 1 March Shull 1  | 901 EASTERN AVI   | ENUE, BALT   | TIMORE, MD. 21231   |
|                            | Physician  |                | 23a. Part1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition |   |  | Approximate<br>Interval Between<br>Onset and Death                  |
| o,                         | /Medical Examiner  1 physicien and as the burial-transit   | Examiner       | Due to (or as a consequence of):   | RTERY DISEA   |  |   |
| Box 68760                  | leath certificate be<br>attending physici<br>I for use as the bu   | in/Medical     | IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy 1  | □Ectopic pregnancy  |  | 23d. Date of delivery   |
| P.O. B                     | res thet the death cer<br>igned by the attendir<br>be detached for use   | Physician/M    |  | Other (specify)   |  | Month Day Year  |
| rds, P                     | quires thet<br>n signed t  | Ď              | Part II. Other significant conditions contributing to death but not resulting in the PERIPHERAL VASCULAR Di  |   | 23e. Did tobacc  | co use contribute to the cause of death? 2 No 3 Probably 4 Munknown |
| Reco                       | ysician: The law requir<br>Is certificete has been si<br>director, page 2 should I   | Completed      | END STAGE RENAL DISEA  | +s=   | 24a. Was an autopsy performed  |   |
| ta                         | an: ]<br>rtificel<br>tor, p  | 0              | 25. Was case referred to medical   | 26. Place of Dea  | th (Check only one)  | 10 163 2010   |
| <u>_</u>                   | hysici<br>his ce<br>I direc  | To B           | examiner? 1 Yes 2 No Hospital: 1 Minpatient 2 ER/Outpatie  | ent 3 DOA Other: 4 Nursing H  | ome 5 Residence  | 6 □Other (Specify)  |
| 0 0                        | ing PI   |                | 27. Manner of Death 1 ☑ Natural 5 ☐ Pending (Month, Day Year) 28b. Time Injury   | Work?   | 28d. Describe how in   | njury occurred  |
| Division of Vital Records, | To the Hospital or Attanding Physician: The law requires thet the death cert within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use a  | Certification: | 2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)  | M 1 ☐ Yes 2 ☐ No  | 28f. Location (Street<br>City or Town, St  | and Number or Rural Route Number,<br>ate)                           |
|                            | ne Hospite<br>n 24 hours<br>ne Funeral   | Medical C      | 29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, dea  2 Medical Examiner: On the basis of examination and/or and manner stated.                     | ith occurred at the time, date and place<br>nvestigation, in my opinion, death occu | , and due to the cause<br>rred at the time, date a   | n(s) and manner as stated.<br>and place, and due to the cause(s)    |
|                            | To the To the Comp   | ×              | 29b. Signature and title of certifier  SALIM RAG HI MD   | 29c. License number   |  | Date signed (Month, Day, Year)                                      |
| )                          | 0  |                | SALIM BAGHLIMD   | RES-000   |  | cember 24.2005  |
| ř                          |  |                | 30. Name and address of person who completed cause of death (Item 23a) (Type SALIM RAGHLI GOOD SAMA)   | LITAN HOSPITAL &  | GOI LOCH   | RAVEN BLVD<br>E- MD- 21239  |
| 2                          | Sta  | ate            | 31. Date filed (Month, Day, Year) 32. Pgistrar's Signature   | Cart .  |  |   |

|                     |  | •              | State of Maryland / Department   State   State   Certain   Certain   State   State   Certain   State   | artment of Health and Me<br>tificate of Death  | ntal Hygien                            | 041140  |
|---------------------|--|----------------|--|--|--|---|
|                     |  |                | 1. Decedent's Name (First, Middle, Last)   |  | . Date of Death<br>Month Da            | 3. Time of Death  |
| 4                   | Physici:<br>/Medic   |                | AUDREY   | SPEALMAN D   | ECEMBER ?                              |   |
|                     | Examin   |                | 4a. Facility Name (If not institution, give street and number)   | 4b. City, Town, or Location of Death   | 4                                      | c. County of Death  |
|                     |  |                | JOHNS HOPKINS BAYVIEW CARE CENTER  | BALTIMORE  |  | ALTIMURE CITY   |
|                     | Funeral  |                | 5. Social Security Number  21.4-22-8005  6. Sex  7. Age (In yrs. last birthday)  1□ M 2√2 F  86 Yrs.   | Months Days Hours Min.   | I. Date of Birth<br>(Month, Day, Year  |   |
|                     | Director   | -              | 214-22-8005 1 M 24 F 86 Yrs.  Usual Residence of Decedent  |  | Aug. 26,1                              | .919   Maryland   |
|                     | land<br>ow   |                | 10a. State 10b. County 10c. City, Town or Lo   | cation   |  | 10d. Inside City Limits   |
|                     | Mary<br>-1 sh  | to             | Maryland Baltimore   | E  | ssex                                   | 1 ☐ Yes 2X No   |
|                     | r 28e  | Director       | 10e. Street and Number   | 10f. Zip Code  | 10g. C                                 | itizen of What Country?   |
|                     | h with   |                | 1000 Franklin Ave. Apt. 607  | 21221  | Ţ                                      | Inited States   |
|                     | deat   | Funeral        | 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?   | Was Decedent of Hispanic Origin? (Speci<br>f Yes, specify Cuban, Mexican, Puerto Ri        | fy Yes or No-<br>can, etc.)            | 14. Race - American Indian,<br>Black, White, etc.                           |
| 9                   | or ite   | Fu             | XXNever Married 2 ☐ Married 1 ☐ Yes XXXNo  | 1 ☐ Yes 2 X No Specify:  | ,,                                     | Specify:  |
| 8                   | thin 72 hours after death with the Maryland<br>e.<br>m. naturel; or Items 23a or 28e-f show<br>Magical Exam recimisation colified at                               | d by           | 3 Widowed 4 Divorced Year or Dates:  |  |  | White   |
| 7                   | "na  | Completed      | (Specify only highest grade completed) (Give   | dent's Usual Occupation<br>kind of work done during most of working<br>DO NOT use retired) | 7                                      | Kind of Business/Industry   |
| 12                  | 3 5 5 8  | m<br>d<br>m    | Elementary/Secondary (0-12) College (1-4or 5+)   | ccounting  | Ma                                     | rtin Marietta   |
| d<br>2              | lled<br>Lygi<br>Iher<br>nt.  |                | 12 Years Ac  | 18. Mother's Name (  |  |   |
| an                  | be de la   | To Be          | John L. Spealman   | Freda J.   | Hasson                                 |   |
| Maryland 21215-0036 | d 2 should be f<br>th and Mental !<br>7 is marked of<br>traumatic eve  |                | 19a. Informant's Name/Relationship (Type, Print) 19b. Mailin   | ng Address (Street and Number or Rural I   | Route Number, City                     | or Town, State, Zip Code)   |
|                     | C1 C2 - 8  |                | Alfred L. Brennar, Jr. (Attorney) 83   | 25 Eastern Blvd. E   | ssex, Mar                              | ryland 21221  |
| Jre,                | 0  |                | 20a. Method of Disposition 1   ■ Burial 2 □ Cremation 3 □ Removal from State  20b. Place of Disposementary, creations are compared to the com  | sition (Name of Da<br>natory or other place)   | te 20c. l                              | Location - City or Town, State  |
| Ĕ                   | Pages<br>nent of<br>ant: if its<br>ury or o  |                |  | Cemetery 12/27/20  | 005 E                                  | Baltimore, Maryland   |
| Baltimore,          | permit. Page<br>Department of<br>Importent: If<br>any injury or<br>once.   |                | 21. Signatur of Funeral Service Licensee   | . Name and Address of Facility<br>ada-Ruck Funeral Ho                                      | me of Dur                              | ndalk, Inc.   |
| _                   | 90 F # 9   | ( )            | Mareson C. Reen 7  | 022 Wise Ave. Dund   | lalk, Mary                             | land 21222  |
|                     |  |                | 23a. Part 1. Enter the disease, or complications that caused the death. Do not ent<br>shock, or heart reduce. List only one cause on each line.  | er the mode of dying, such as cardiac or   | respiratory arrest,                    | Approximate<br>Interval Between<br>Onset and Death                          |
| M                   | Priysician   | 4              | Immediate Cause (Final disease or condition a BREAST CA  | NCER   |  | Oriot and Dodg  |
|                     | /Medical<br>Examiner   |                | resulting in death)  Due to (or as a consequence of):  |  |  |   |
| М                   |  | _              | Sequentially list conditions, if any leading to immediate Due to (or as a consequence of):   |  |  |   |
| <i>J</i> = -        | ted<br>nsit  | nin nin        | cause. Enter Underlying  |  |  |   |
| 4 ~                 | al-tra   | Examiner       | that initiated events c. Due to (or as a consequence of):  |  |  |   |
| 8760,               | The law requires that the death certificate be executed ate has been signed by the attending physicien and page 2 should be detached for use as the burial-transit | dicai          | d  |  |  |   |
| 9                   | ifficat<br>g phy<br>as th  | edi            | -  |  |  |   |
| Вох                 | eath certific<br>attending p   | N/N            | IF FEMALE: 23b. Was decedent pregnant  1 □ Live birth 2 □ Fetal death 3 □  | ⊒Ectopic pregnancy   |  | 23d. Date of delivery   |
|                     | deatine atte   | Physician/Me   | in the past 12 months?  1 Yes 2 Prognant at time of death 5  | Other (specify)  |  | Month Day Year  |
| P.0                 | at the de<br>by the a  | hy             | 9 Unknown  |  | 00 01444                               | and the second second   |
|                     | res tha<br>igned<br>be del   |                | Part II. Other significant conditions contributing to death but not resulting in the u   | nderlying cause given in Part I.   |  | use contribute to the cause of death?  2 No 3 Probably 4 Winknown           |
| ord                 | w require<br>been sign   | ted            |  |  |  |   |
| Records,            | e law<br>has b<br>ye 2 st  | Completed by   |  |  | 24a. Was an autopsy performed?         | 24b. Were autopsy findings available prior to completion of cause of death? |
| E H                 | yeicien: The is certificate hadirector, page   | S              |  |  | 1□ Yes 2₽N                             | o 1 Yes 2 No  |
| Vital               | icien: Th<br>certificate<br>rector, pag  | Be             | 25. Was case referred to medical examiner?  Hospital:  | 26. Place of Death (   |  |   |
| To                  |  | 5 T            | 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 2. RAOutpatient 2. RAOu | 1 3 DOA 4 Nursing Home   | e 5 ∐ Residence<br>d. Describe how inj | 6 ☐Other (Specify) urv occurred   |
|                     | ling<br>After<br>fune  | tion           | 1 ☑ Natural 5 ☑ Pending (Month, Day Year) Injury<br>2 ☑ Accident investigation   | Work?<br>M 1 ☐ Yes 2 ☐ No  | ,                                      | ,   |
| Division            | Attending Ph<br>er death.<br>ector: After th<br>by the funeral   | fica           | 3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, st   | reet, factory, office 28   | If. Location (Street a                 | and Number or Rural Route Number,   |
| Ö                   | after<br>Dire  | Certification: | 4 Homicide building, etc. (Specify)  |  | City or Town, Sta                      | 10)   |
|                     | To the Hospitel or Attend within 24 hours after death To the Funerel Director: completely filled in by the 1   |                | 29a. Certifier 1 Certifying Physician: To the best of my knowledge, deat (Check only 2 Medical Examiner: On the basis of examination and/or in   | h occurred at the time, date and place, an   | nd due to the cause(                   | s) and manner as stated.  |
|                     | he H<br>in 24<br>he Fi<br>plete  | Medical        | one) and manner stated.  |  |  |   |
|                     | with<br>To t   | Σ              | 29b. Signature and title of certifier  | 29c. License number  |  | ate signed (Month, Day, Year)   |
|                     |  |                | Examaran MD  | D006316  | 7 DRG                                  | LEMBER 22 2005  |
|                     | in   |                | 30. Name and address of person who completed cause of death (Item 23a) (Type,  |  | 0                                      | BALTINOZE   |
|                     | -  |                |  | MOPKINS BAYVIEW  | CIRCLE                                 | MD 21224  |
|                     | Sta<br>Regist  | ate<br>rar     | 31. Date filed (Month Day, Year) Registrar's Signature   | ملك  |  |   |
|                     |  |                |  |  |  |   |

|                            |  |                  | 1 - For<br>State<br>Registrar   | State of Ma  |                         | artment<br>rtificate         |                        |                            | and M                   |   | giene<br>Reg. No.          | 05                        | 4174  |                 |
|----------------------------|--|------------------|---|--|-------------------------|------------------------------|------------------------|----------------------------|-------------------------|---|----------------------------|---------------------------|---|-----------------|
| *                          | Physici  | an               | 1. Decedent's Name (First, Middle, Las  |  | 0                       |                              |                        |                            |                         | 2. Date of De<br>Month                  | Day                        | Year                      | 3. Time of De                                 | ath             |
|                            | /Medic   |                  |   | nleupner,  | Sr.                     | T                            |                        | Location of                | 15 1                    | 12                                      | 22                         | ounty of Dea              | 1433  | M               |
| -                          | Examin   | er               | 4a. Facility Name (If not institution, give<br>Penninsula Gener   |  | 1                       | ,                            |                        | bury                       | or Death                |   |                            | √icomi                    |   |                 |
|                            | Funeral  |                  | 5. Social Security Number 6. Se   | 7. Age   | (In yrs. last birthday, | If Under                     | 1 Year                 | If Under                   |                         | 8. Date of Bir                          |                            |                           | thplace (State or F                           | oreign          |
|                            | Director   |                  | 217-01-0533   | XM 2□F   | 88 Yrs.                 | Months                       | Days                   | Hours                      | Min.                    | 8. Date of Bir<br>(Month, Da<br>Sept. 1 | 7,191                      | 7 Mar                     | yland   |                 |
|                            | pu ,   |                  | Usual Residence of Decedent  10a. State 10b. County   |  | 10c. City, Town or L    | coation                      |                        |                            |                         |   |                            |                           | 10d. Inside City                              | imits           |
|                            | aryla<br>•hov  | ō                |   |  |                         |                              |                        |                            |                         |   |                            |                           | 1 Tyes 2                                      |                 |
|                            | 288-1  | ect              | MD Wicom  10e. Street and Number  | 100  | Salish                  | 10f. Zip                     | Code                   |                            |                         | -                                       | 10g. Citize                | n of What C               |   |                 |
|                            | 3a or  | Funeral Director | 1109 South Schum  | aker Drive   |                         |                              | 1804                   |                            |                         |   |                            | S.A.                      |   |                 |
|                            | death  | ner              | 11. Marital Status  | 12. Was Decedent E<br>Armed Forces?                | ver in U.S. 13.         | Was Deced                    | ent of Hi              | spanic Ori                 | gin? (Spe               | cify Yes or No<br>Rican, etc.)          | )- 14.                     | Race - Am<br>Black, Wh    | erican Indian,                                |                 |
| 98                         | or the   | y Fu             | 1 Never Married 2 Marned  | 1 Yes 2 □ No                                       | WWIT                    | 1 Yes 2                      |                        | Specify:                   | , 1 00110               | 110211, 010.7                           |                            | ecify:                    | White   |                 |
| 215-0036                   | within 72 hours after death with the Maryland<br>ene.<br>then "natural", or items 23s or 28e-1 ehow<br>te Medical Exacting frault be rediffed at   | d by             | 3   Widowed 4 □ Divorced  15. Decedent's Ed   |  |                         | edent's Usua                 |                        | tion                       |                         |   |                            | of Business               |   |                 |
| 15                         | in 72<br>n "nai  | Completed        | (Specify only highest gra-  | de completed)                                      | (Give                   | kind of wor<br>DO NOT us     | k done a               | furina mos                 | t of worki              | ng                                      | TOD. KING                  | OI DUSINGS:               | viridustry                                    |                 |
| 212                        | d with<br>giane.   | mo;              | Elementary/Secondary (0-12)   | College (1-4or 5+                                  | )                       | S                            | ales                   | sman                       |                         |   | Con                        | struc                     | tion Equi                                     | p.              |
|                            | al Hy<br>fother  | Bec              | 17. Father's Name (First, Middle, Last)   |  |                         |                              |                        |                            |                         | (First, Middle                          |                            | mame)                     |   |                 |
| yla                        | Ment<br>Ment<br>marked   | To               | Charles J. Schl   | · · · · · · · · · · · · · · · · · · ·              |                         |                              |                        |                            |                         | beth L.                                 |                            |                           |   |                 |
| Maryland                   | 12 should be filed within h and Mental Hygiene. 7 Is marked other then "traumatic event, to Me.  |                  | 19a. Informant's Name/Relationship (7) Michael Schleupne  |  |                         | ing Address<br>I 7 Edw       | •                      |                            |                         | Route Numb<br>Baltimo                   |                            |                           |   |                 |
|                            | permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: if Item 27 Is marked other then "natural", or Itema 23a or 28e-f show my injury or other traumatic event, it a Medical Exa., if errinal be recitived at ance. |                  | 20a. Method of Disposition  | , 01.  | 20b. Place of Disp      | osition (Nam                 | e of                   |                            |                         | ate                                     |                            | J                         | Town, State                                   |                 |
| Baltimore,                 | Pages<br>nent of I<br>ant: If It<br>ury or o   |                  | 1  Burial 2  Cremation 3  □ 4  □ Donation 5  □ Other (Specify   | Removal from State                                 | Loudon                  |                              |                        |                            | 12/2                    | 8/05                                    | Balti                      | more.                     | Maryland                                      |                 |
| alti                       | permit. F<br>Departm<br>Importer<br>any injur  |                  | 21. Signature of Funeral Service Licen  |  | er Cain 2               |                              |                        |                            |                         |   |                            |                           |   |                 |
| m                          | Depar<br>Impo  |                  | 1 down  | a Cae  |                         | 5305 F                       | larfo                  | ord R                      | oad                     | Baltimo                                 | re,Ma                      | rylan                     | d 21214                                       |                 |
| 4                          |  |                  | 23a. Part1. Enter the disease, or comp<br>shock, or heart failure. List only                                | dications that caused to<br>one cause on each line | he death. Do not en     | ter the mode                 | of dying               | g, such as                 | cardiac o               | r respiratory a                         | rrest,                     |                           | Approximate<br>Interval Betwe<br>Onset and De |                 |
| 7                          | Physician<br>/Medical  |                  | Immediate Cause (Final disease or condition resulting in death)   | a  |                         | ASW                          | 2                      |                            |                         |   |                            |                           | 5ycans  |                 |
| -                          | Examiner   |                  |   | Due to (or as a                                    | consequence of);        | AURTI                        | , C                    | D-ND                       | ()(                     |   |                            |                           | SYFAR   | Q               |
|                            |  | ler              | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | b. Due to (or as a                                 | euneuquenes of):        | HUICH                        | C 7                    | 16140                      |                         |   |                            |                           | 7 0711  | -               |
| þ                          | ate be executed oblysicien and the burial-transit  | Examiner         | that initiated events   | С.   |                         |                              |                        |                            |                         |   |                            |                           |   |                 |
| ,<br>,<br>,                | e exe  | Ex               | resulting in death) Last  | Due to (or as a                                    | consequence of):        |                              |                        |                            |                         |   |                            |                           |   |                 |
| 8760,                      | cate b<br>physic<br>the b  | edicai           |   | d  |                         |                              |                        |                            |                         |   |                            |                           |   |                 |
| 9 X                        | leath certifica<br>attending ph<br>I for use as th   | /Me              | 1F FEMALE:<br>23b. Was decedent pregnant  | 23c. If yes, outcome of                            | f pregnancy             |                              |                        |                            |                         |   | 230                        | I. Date of de             | livery  |                 |
| Вох                        | death<br>a atter   | Physician/M      | in the past 12 months? 1 ☐ Yes 2 ☐ No   | 1☐Live birth 2<br>4☐Pregnant at t                  |                         | □Ectopic pre<br>□ Other (spe |                        |                            |                         |   | 200                        | Month                     | Day Yea                                       | ır              |
| P.O.                       | that the de<br>ed by the a<br>detached f   | hys              | 9 Unknown   | 9□ Unknown   |                         |                              |                        |                            |                         | _                                       |                            |                           |   |                 |
|                            | Se De G  | by P             | Part II. Other significant conditions of  | ontributing to death bu                            | t not resulting in the  | underlying ca                | use give               | en in Part I               | •                       |   |                            |                           | o the cause of dea                            |                 |
| ord                        | w requir<br>been si<br>shoutd  | ted              |   |  |                         |                              | _                      |                            |                         | 10                                      | Yes 2□I                    | √lo 3 ∏ F                 | robably 4 Uni                                 | nown            |
| ec                         | staw<br>nas b  | Completed        |   |  |                         |                              |                        |                            |                         | 24a. Was<br>auto                        | psy                        | prior to                  | utopsy findings ava<br>completion of cau      | alable<br>se of |
| E H                        | : The<br>cate h  |                  |   |  |                         |                              |                        |                            |                         | 1 ☐ Yes                                 | 20 No                      | death?<br>1 ☐ Ye          | s 2□No  |                 |
| Zii.                       | Physicien: The law<br>this certificate has t<br>ral director, page 2 s   | Be               | 25. Was case referred to medical examiner?  | Hospital:  | - ×                     |                              | Othe                   |                            |                         | (Check only                             |                            |                           |   |                 |
| o                          | Phys<br>r this<br>aral di  | 5:1              | 1 Yes 2 No 27. Manner of Death  | 28a. Date of Injury                                | 28b. Time               |                              | 3c. Injury             | at                         |                         | ne 5 Resi                               |                            |                           | ecify)  |                 |
| Division of Vital Records, | Attending<br>ir death.<br>ector: After<br>by the fune  | Certification:   | 12 Naturat 5 ☐ Pending<br>2 ☐ Accident investigation  | (Month, Day  | Year) Injury            | м                            | Work                   | <br Yes 2□                 | No                      |   |                            |                           |   |                 |
| <u>Vis</u>                 | r Atte<br>er deg<br>recto<br>by th   | tific            | 3 Suicide 6 Could not be determined   | 28e. Place of Injurbuilding, etc.                  | ry - At home, farm, si  | treet, factory               | office                 |                            |                         | 28f. Location (<br>City or To           | Street and I<br>wn, State) | lumber or F               | iural Route Numbe                             | r,              |
| Ö                          | itat or<br>irs afte<br>rel Dir<br>ted in   | Cer              |   |  |                         |                              |                        |                            |                         |   |                            |                           |   |                 |
|                            | To the Hospital or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certific completely filled in by the funeral director,  | edicai           | 29a. Certifier  | ysician: To the best of                            | examination and/or i    | th occurred anvestigation,   | at the tim<br>in my op | ne, date an<br>pinion, dea | d place, a<br>th occurr | and due to the<br>ed at the time,       | cause(s) and pl            | d manner a<br>ace, and du | s stated.<br>e to the cause(s)                |                 |
|                            | o the<br>ithin 2<br>o the<br>omplei  | Med              | 29b. Signature and title of certifier   | and manner stat                                    | ed.<br>                 | 29c                          | License                | number                     |                         |   | 29d. Date s                | igned (Mor                | th, Day, Year)                                |                 |
|                            | F 3 F 3  |                  | > nanch   |  |                         |                              |                        |                            | 59                      |   |                            | _                         | •   | 3 6             |
|                            | , ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,  |                  | 30. Name and address of person who  | completed cause of de                              | ath (ttem 23a) (Type    | , Print)                     |                        |                            | Į.                      |   | VICE                       | ハンロン                      | 40 1700                                       | , )             |
|                            | 10+1   |                  | DR. USHA NA   | 753AN  | 1415                    | SOUTH                        | N                      | V/5/0                      | riv .                   | 51, 5                                   | HUS                        | BUR                       | 23 4 200<br>MD 2180                           | 4               |
| \$\frac{1}{2}              | Sta  | ate              | 31. Date filed (Month Par Year) 7   | 005 32. Fegistra                                   | r's Signature           | Carles                       |                        |                            |                         |   |                            |                           |   | ,               |

Michael Schleuphar

|                            |   |                   | For<br>State<br>Registrar   | •   | partment of Health and<br>Certificate of Death   | Mental Hygier  | 11115 41/4/   |
|----------------------------|---|-------------------|---|---|--|--|---|
|                            | Physici<br>/Medic   |                   | Decedent's Name (First, Middle, Last, HENRY   |   | SCHLEIDER  |  | 3. Time of Death<br>4:35 Р м  |
|                            | Examin  |                   | 4a. Facility Name (If not institution, give NORTH OAKS HEAL]  | TH CENTER   | 4b. City, Town, or Location of Deal  | 1  | 4c. County of Death BALTIMORE                                       |
|                            | Funeral<br>Director   |                   | 5. Social Security Number 6. Security Number 212-03-5005  | 7. Age (In yrs. last birthd   | Months Days Hours Min.   | 8. Date of Birth<br>(Month, Day, Yea<br>09/25/1910           | 9. Birthplace (State or Foreign Country) MD                         |
|                            | Maryland<br>-f show<br>ii-d at  | tor               | 10a. State 10b. County MD BALTIMO   | DRE PIKES   | r Location<br>VILLE  |  | 10d. Inside City Limits<br>1 ☐ Yes 2 ☐ No                           |
|                            | er death with the Marylan<br>Items 23a or 28a-f show<br>ner nast be notified at   | ai Director       | 10e. Street and Number 725 MT. WILSON   | ANE APT. #638   | 10f. Zip Code 21208  |  | Citizen of What Country?  |
| 036                        | within 72 hours after death with the Maryland<br>ene.<br>than "natural", or items 23a or 28a-f show<br>Its Modical Exeminer must be modified at | l by Funerai      | 11. Marital Status  1 Never Married 2 Married  3 X Widowed 4 Divorced   |   | 13. Was Decedent of Hispanic Origin? (S<br>If Yes, specify Cuban, Mexican, Puer<br>1 ☐ Yes 2 X No Specify: | Specify Yes or No-<br>to Rican, etc.)                        | 14. Race - American Indian,<br>Black, White, etc.<br>Specify: WHITE |
| 21215-0036                 | 7 5 5 7   | Completed         | 15. Decedent's Edu<br>(Specify only highest grad<br>Elementary(Secondary (0-12)                               | e completed) (G   | ecedent's Usual Occupation<br>live kind of work done during most of wo<br>e. DO NOT use retired)<br>R      | rking  | Kind of Business/Industry YLAND STEEL DRUM CO.                      |
| Maryland                   | should be filed<br>nd Mental Hygi<br>s marked other<br>umatic event, I  | To Be C           | 17. Father's Name (First, Middle, Last)  ISRAEL   | SCHLE   | EIDER MARY   | me (First, Middle, Maid                                      | MOSSEY  |
|                            | 1 and 2<br>Health a<br>Sm 27 Is   |                   | 19a. Informant's Name/Relationship (T)  NICKY SCHLEIDER /  20a. Method of Disposition                         | DAUGHTER 204  | lailing Address (Street and Number or REAST READ STREET is position (Name of                               | - BALTIMORE  |   |
| Baltimore,                 | t. Page<br>rtment o<br>rtant: If<br>sjury or  |                   | 1 M Burial 2 Cremation 3 F<br>4 Donation 5 Other (Specify)  21. Signature of Funeral Service Licens           | Removal from State BETH TFI   | LOH CONG. 12/2   | 26/2005 WO   | ODLAWN, MD N & BROS., INC.  |
| Ba                         | Depar<br>Impor<br>any ir  | 2 2               | 23a. Part1. Enter the disease, or compl   | ications that caused the death. Do not  | 8900 REISTERSTOW enter the mode of dying, such as cardia   | N ROAD - PI  | KESVILLE, MD 21208  Approximate Interval Between                    |
|                            | Physician<br>/Medical<br>Examiner   |                   | shock, or heart failure. List only o<br>Immediate Cause (Final<br>disease or condition<br>resulting in death) |   | er's Disease   | 4-72-11-51-52-52-52-52-52-52-52-52-52-52-52-52-52-           | Onset and Death   |
| )0°, ×                     | ite be executed<br>iysician and<br>ne burial-transit  | l Examiner        | if any, leading to immediate cause. Enter Underlying  | Due to (or as a consequence of):  Due to (or as a consequence of):                        |  |  |   |
| P.O. Box 68760,            | death certificate<br>e attending phy.<br>id for use as the  | Physician/Medical | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown                       | d   | 3 □Ectopic pregnancy 5 □ Other (specify)   |  | 23d. Date of delivery<br>Month Day Year                             |
|                            | luires that<br>n signed to<br>Ild be deta   | þ                 | Part II. Other significant conditions co  | ntributing to death but not resulting in the  | , ,  |  | o use contribute to the cause of death? 2 No 3 Probably 4 Hunknown  |
| Division of Vital Records, | Physician: The law requires that the this certificate has been signed by the fall director, page 2 should be detached.                          | Completed         | peripheral Jas  | ombosis, chronic  | kidney disea   | 24a. Was an autopsy performed 1 Yes 2 14                     |   |
| of Vita                    |   | To Be             | 25. Was case referred to medical examiner? 1 1 Yes 2 1 No 27. Manner of Death                                 | Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpa<br>28a. Date of Injury<br>(Month, Day Year) 28b. Tim | atient 3 DOA Other: 4 Nursing I  | ath (Check only one)  Home 5 Residence  28d. Describe how in |   |
| vision                     | if or Attending I<br>after death.<br>Director: After<br>d in by the funer   | Certification;    | 1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined        |   | M 1 ☐ Yes 2 ☐ No   | 28f. Location (Street<br>City or Town, Sta                   | and Number or Rural Route Number,<br>ate)                           |
| ā                          | To the Hospital or Ati<br>within 24 hours after d<br>To the Funeral Direct<br>completely filled in by   | Medical Cer       | 29a. Certifier 1 ☐ Certifying Phy (Check only one)  | iner: On the basis of examination and/o   | leath occurred at the time, date and place or investigation, in my opinion, death occ                      | e, and due to the cause<br>urred at the time, date a         | (s) and manner as stated. and place, and due to the cause(s)        |
| )                          | To the within 2 To the comple   | Mec               | 29b. Signature and title of certifier   | Balrit, M, D.   | 29c. License number  |  | Date signed (Month, Day, Year)  Cember 21, 2005                     |
|                            | le  |                   | 30 Name and address of person who c   | ompleted cause of death (Item 23a) (Ty  | rpa, Print)  a Street, Suite 2   | 00 Reister   | 5 town, MD 21134  |
|                            | Sta<br>Regist   |                   | 31. Date filed (Month, Day, Year)  DFC 2 7 200  | 39. Registrar's Signature   | porti  | ,  | 7   |

| Physician (Port Mann) First Mann Ford Mann, Lard Park Mann, La |             |  |          | . For  | State of Marylar  | nd / Departme   | ent of Health and   | Mental Hygi                                     | ene  | 1 |
|--|-------------|--|----------|--|---|---|---|---|--|---|
| Physician (Corden)  White State of the corden and another the service and anot |             |  |          |  |   | Certifica   | ate of Death  |   |  | 41/43                                   |
| State   Control   Contro   |             | /Medio   | al       | Verome Tou   | uson  | 4. 0  | T   | Dec   | Day Year 22 200                              | 5 849PM                                 |
| Continued   Cont   |             | Funeral  | er       | University of Ma<br>5. Social Security Number 6. Se                    | yland Medical x 7. Age (In yrs.                         | Jast birthday) If Und                                 | Baltmore<br>Her 1 Year   If Under 24 Hrs                        | 8. Date of Birth                                | Year) Omis 9. Bir                            | Athplace (State or Foreign              |
| The state of the s |             | p  |          | Usual Residence of Decedent  | 10c. Ci   | ty, Town or Location                                  |   | 77777   | 7. 150                                       | /                                       |
| Company of the property of t   |             | the Mary<br>28a-f sho                                | ector    |  | A   | BI  | 9LTTHORE  | E CITY  | G Citizen of What So                         |   |
| Company of the property of t   |             | s 23s or   | ral Dir  | 341 GWY1   | IN AVEN   | UE  | 2125  | 29 '  | us   | SA.                                     |
| The properties of the properti | 980         | 1  | by       | 1 ☐ Never Married 2 🛱 Married  | Armed Forces?<br>1 ☐ Yes 2 X No<br>If Yes, Give         | If Yes, sp  |   | to Rican, etc.)                                 | Black, Whit                                  |   |
| The proposed of the property o |             | thin 72 ho<br>e.<br>en "netur                        | pleted   | (Specify only highest gra-   | de completed)   | 16a. Decedent's U:<br>(Give kind of v<br>life. DO NOT | work done during most of wo<br>use retired)                     | rking   |  |   |
| Shorted 2 Commanders   20 Comm | 21          | a filed wil<br>Il Hygien<br>other th                 | е Соп    | 12 THGRADE   |   | MACH  |   |   |  | TURING CO.                              |
| Shorted 2 Commanders   20 Comm | ırylar      | should by  | ToE      |  |   |   |   |   |  |   |
| Sharisal 2 (Special Special Sp |             | 1 and 2 s<br>Health ar<br>em 27 is<br>ther trau      |          | CATHERINE TOO  | USON (MOTHER  | 341G  |   |   |  |   |
| 23a. Part. Enter the disease, or compleations that caused the death. Or not enter the mode of dying, such as cardiac or respiratory arrest.  Approximate shock, or heart failure. List only one cause on asch line.  Approximate shock, or heart failure. List only one cause on asch line.  Approximate shock, or heart failure. List only one cause on asch line.  Approximate shock, or heart failure. List only one cause on asch line.  Approximate shock, or heart failure. List only one cause on asch line.  Approximate shock, or heart failure. List only one cause on asch line.  Approximate shock, or heart failure. List only one cause on asch line.  Approximate shock, or heart failure. List only one cause on asch line.  Approximate shock, or heart failure. List only one cause on asch line.  Approximate shock, or heart failure. List only one cause on asch line.  Approximate shock, or heart failure. List only one cause on asch line.  Approximate shock, or heart failure. List only one cause on asch line.  Approximate shock. Or heart failure. List only one cause on asch line.  Approximate shock.  Approxima | timor       | 90 = 5   |          | 1∑Surial 2 ☐ Cremation 3 ☐   | Removal from State :                                    | ESTERNS   | TAR CEME 12-  |   | 1  |   |
| Physician Modical Examinor    Physician Modical Examinor   Physician Modic | Ball        | Demit<br>Depend<br>Import<br>any n                   |          | 21. Signature of Funeral Service Licen                                 |   | 22. Name  | and Address of Facility   | BROWN<br>ON AVE                                 | JR. FUNE                                     | MD. 21217                               |
| Color   Colo   |             | Physician  |          | shock, or heart failure. List only of<br>Immediate Cause (Final        | lications that caused the dea<br>ne cause on each line. | th. Do not enter the m                                | ode of dying, such as cardia                                    | c or respiratory arres                          | st,  | Interval Between                        |
| Course sea an analysis of the season of the  |             | /Medical   |          | resulting in death)  | Due to (or as a consec                                  | quence of):   | carditie  | 119   |  | Landle                                  |
| The companies of the    | 7           | t<br>Insit   | mlner    | cause. Enter Underlying<br>Cause (Disease or injury                    | b. Due to (or as a consec                               | quence of):   | TWENTER   |   |  | THOUGH                                  |
| FFEMALE   23b. Was decedent pregnant in the past 12 months?   1   1   1   1   1   1   1   1   1  | 760,        | te be exec<br>ysician and<br>e burial-tra            |          | resulting in death) Last   | Due to (or as a consec                                  | quence of):   |   |   |  |   |
| The state of death of the cause of death of  | Box 6       | death certific<br>e attending p<br>id for use as     |          | 23b. Was decedent pregnant<br>in the past 12 months?<br>1 □ Yes 2 □ No | 1 ☐ Live birth 2 ☐ Feta<br>4 ☐ Pregnant at time of c    | al death 3 □Ectopic                                   |   |   |  |   |
| 24a. Was an autopsy performing available prior to completion of cause of death?   1   yes 2   No   25. Was case referred to medical examiner?   1   yes 2   No   25. Was case referred to medical examiner?   1   yes 2   No   25. Was case referred to medical examiner?   1   yes 2   No   25. Was case referred to medical examiner?   1   yes 2   No   26. Place of Death   Check only one)   27. Manner of Death   1   Natural    |             | signed by  | þ        | Part II. Other significant conditions or                               | ntributing to death but not res                         | sulting in the underlying                             | g cause given in Part I.  |   | t .  |   |
| The composition of the cause of the control of the cause of the caus   | ecor        |  | nplete   |  |   |   |   | 24a. Was an                                     | 24b. Were au                                 | topsy findings available                |
| 1   Yes 2   No   No   No   No   No   No   No   | ital R      | an: The<br>tificate b                                | 0        |  |   | 11000000  | 26. Place of De   |   |  | 2 ☐ No                                  |
| 29a. Certifier (Chieck durity one)  29a. Certifier (Chieck durity one)  29b. Signature and title of certifier  29b. Signature and title of certifier  30. Name an address of pers who completed cause of death (Item 23a) (Type, Print)  State  31. Date filed (Month, Day, Year)  32. Registrar's Signature   | <u>&gt;</u> | hyaici<br>his cer<br>I direc                         |          |  | 1 Nipatient 2L  | ER/Outpatient 3 1                                     | 1 04  |   |  | cify)                                   |
| 29a. Certifier (Chieck durity one)  29a. Certifier (Chieck durity one)  29b. Signature and title of certifier  29b. Signature and title of certifier  30. Name an address of pers who completed cause of death (Item 23a) (Type, Print)  State  31. Date filed (Month, Day, Year)  32. Registrar's Signature   | o uo        | ding P<br>h.<br>After ti<br>funera                   |          | 1 Natural 5 ☐ Pending  | 28a. Date of Injury<br>(Month, Day Year)                | Injury  |   | 28d. Describe how                               | injury occurred                              |   |
| 29a. Certifier (Check only one)  29a. Certifier (Check only one)  29b. Signature and title of pertifier  29b. Signature and title of pertifier  29c. License number  29c. License number  29d. Date signed (Month, Day, Year)  30. Name an address of pers, who completed cause of death (Item 23a) (Type, Print)  43c. Registrar's Signature  31. Date filed (Month, Day, Year)  32. Registrar's Signature  | Divisi      | i or Atten<br>after deat<br>Director:<br>I in by the | ertifica | 3 Suicide 6 Could not be   | 28e. Place of Injury - At h<br>building, etc. (Speci    | ome, farm, street, fact                               |   | 28f. Location (Stre<br>City or Town,            | eet and Number or Ru<br>State)               | ural Route Number,                      |
| 30. Name an address of pers who completed cause of death (Item 23a) (Type, Print)  Kimberly M Lumpkins MD 22 S Greene St Baltimore MD 21201  State 31. Date filed (Month, Day, Year) 32. Registrar's Signature   | _           | Hospita<br>4 hours<br>Funaral                        | icai C   | (Crisck Only Z Medical Exam  | iner: On the basis of examina                           | owledge, death occurre                                | ed at the time, date and place<br>on, in my opinion, death occi | e, and due to the cau<br>arred at the time, dat | use(s) and manner as<br>e and place, and due | stated. to the cause(s)                 |
| 30. Name an address of pers who completed cause of death (Item 23a) (Type, Print)  Kimberly M Lumpkins MD 22 S Greene St Baltimore MD 21201  State 31. Date filed (Month, Day, Year) 32. Registrar's Signature   |             | o the<br>ithin 2<br>o the<br>omple                   | Med      | 01107  | and manner stated.                                      |   |   |   |  |   |
| Kimberly M Lumpkins MD 22 S Greene St Baltimore MD 21201 State 31. Date filed (Month, Day, Year) 32. Registrar's Signature   |             | ⊢ s ⊢ ŏ  |          | 1 Jumn   | King MID  |   | 15813   |   | Dar 27                                       | 2005                                    |
| State 31. Date filed (Month, 'Day, Year) 32. Registrar's Signature   |             | 3  |          | 30. Name any address of person who of                                  | ompleted cause of death (Iter                           |   | reens St R-   | hmana   | MD 2120                                      | 1                                       |
| Registrar DEC 2 7 2005   |             |  | 1.0      |  | 32. Registrar's Signa                                   | ature   | I WILL OF THE   | LIMORE  | -IN 6160                                     |   |

FIGHTAS, FRANKA

|            |  |                | 1 - State<br>Registrar   | State of M  |   | epartment of F<br>Certificate of                                |   | Mental Hy                             | giene)                             | 15 1                                     | 1744   |
|------------|--|----------------|--|---|---|---|---|---------------------------------------|------------------------------------|--|--|
|            | Physic   | an             | Decedent's Name (First, Middle, Last   |   |   |   |   | 2. Date of De<br>Month                | eath<br>Day                        | Year                                     | 3. Time of Death                                   |
|            | /Medi  |                | Frank Arthur   |   |   |   |   | Decem                                 | ber 18,                            | 2005                                     | 520 AM   |
| )<br>&     | Examir<br>Funeral<br>Director  | ner            | 4a. Facility Name (If not institution, give  BALT I HORE WAShir.  5. Social Security Number  6. Se  216-82-7657  | YTON HE   | o)<br>CIICAL CENE<br>ge (In yrs. last birthi<br>46 Yr | day) If Under 1 Year<br>Months Days                             | BURNIE  If Under 24 Hrs Hours Min.                    |                                       | AA                                 | 9. Birthp                                | place (State or Foreign MD                         |
|            | pu &   |                | Usual Residence of Decedent  10a. State 10b. County  |   | 10c. City, Town o                                     | or Logation   |   |                                       |                                    | <del></del>                              | IOd Inside Oits Limite                             |
|            | Aaryla<br>Febov  | 0              | Maryland Anne Ar   | rundol  | Toc. City, Town o                                     |   | asadena   |                                       |                                    |  | 10d. Inside City Limits 1 ☐ Yes 2 ☐ No             |
|            | 28a-   | Director       | 10e. Street and Number   | under   |   | 10f. Zip Code   |   |                                       | 10g. Citizen o                     | f What Cour                              |  |
|            | h with   | al D           | 716 207th Street   |   |   |   | 21122   |                                       |                                    | USA                                      |  |
| 5-0036     | s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "natural", or itema 23a or 28a-1 show other traumatic event, the Madical Enarth at Final be notified at | by Funeral     | 11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced   | 12. Was Decedent Armed Forces 1 Yes 2 If Yes, Give Year or Dates: | (No   | 13. Was Decedent of H<br>If Yes, specify Cuba<br>1 ☐ Yes 2 ☒ No | lispanic Origin? (S<br>an, Mexican, Puerl<br>Specify: | pecify Yes or No<br>o Rican, etc.)    | Spec                               | ace - Americ<br>lack, White,<br>hify: Wh |  |
| 5          | 72 ho<br>natu  | etec           | 15. Decedent's Edu<br>(Specify only highest grad   |   | (0  | ecedent's Usual Occup<br>Give kind of work done                 | during most of wor                                    | rking                                 | 16b. Kind of                       | Business/in/                             | dustry   |
| 2121       | within<br>ane.<br>than   | Completed by   | Elementary/Secondary (0-12)  | College (1-4or  | 5+)   | ife. DO NOT use retired<br>Sorter                               | d)  |                                       | 1                                  | UPS                                      |  |
| 2          | Hygie<br>other   | Be Co          | 17. Father's Name (First, Middle, Last)  |   |   | 301 001   | 18. Mother's Nar                                      | ne (First, Middle                     |                                    |  |  |
| <u>lan</u> | i Mental<br>i Mental<br>narked o   | To B           | Frank Tho  | mas   |   |   | Gladys  | Gre                                   | eaver                              |  |  |
| Maryland   | and h  |                | 19a. Informant's Name/Relationship (T  | rpe, Print)   | 19b. N  | failing Address (Street   | and Number or Ru                                      | ıral Route Numb                       | er, City or Tow                    | n, State, Zip                            | Code)  |
|            | and<br>lealth<br>m 27<br>her tr  |                | Fran O. Thomas   | (spouse   |   | 6 207th St  | reet, Pa  |                                       |                                    |  |  |
| <u>S</u>   | Pages 1<br>nent of H<br>int: If its<br>iry or otl  |                | 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ F  |   | cometon   | isposition (Name of<br>crematory or other plac                  | Dec.  | Date<br>22                            | 20c. Location                      | - City or To                             | own, State   |
| altimore,  | 교육환경 .   |                | 4 ☐ Donation 5 ☐ Other (Specify)  21. Signatur of Funeral Service Licers   | -   | Glen Ha   | oven Cemete 22. Name and Addres                                 |   | 05                                    | Glen B                             | urrie.                                   | , Maryland   |
| Ba         | Depa<br>Impo<br>eny i  |                | 2 Holyman Control 200  |   |   |   | ıntain Ro   |                                       |                                    |  | ne, P.A.   |
| N. A.      | Cate be executed // Medical Examiner and physician and the burial-transit  | Examiner       | 23a. Part   Enter the disease, or comb shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last   | Due to (or as   | Myecu   | t enter the mode of dyin  |   | or respiratory a                      |                                    |  | Approximate<br>Interval Batween<br>Onset and Death |
| 8760,      |  | dicai          | (  | d   |   |   |   |                                       |                                    |  |  |
| 9          |  | Medi           | 15.55.40.5   | V   |   |   |   |                                       |                                    |  |  |
| O. Box     | at the death certifi<br>by the attending I<br>tached for use as  | Physician/Me   | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  |   | e of pregnancy<br>2  Fetal death<br>at time of death  | 3 ☐ Ectopic pregnancy<br>5 ☐ Other (specify)                    |   |                                       |                                    | ate of delive<br>fonth                   | ery<br>Day Year                                    |
| ecords, P  | law requires that the<br>as been signed by th<br>2 should be detache   | by             | Part II. Other significant conditions co   | ntributing to death I   | but not resulting in the                              | ne underlying cause giv   | en in Part I.   | 23e. Did t                            | <u>.</u>                           |  | ne cause of death?                                 |
| Y          | The<br>ate h<br>page   | e Completed    | 25. Was appointed to medical   |   |   |   |   | 1 Yes                                 | psy<br>prmed?<br>2 \( \text{No} \) | prior to cor<br>death?                   | psy findings available mpletion of cause of 200 No |
| VII        | Phyaician:<br>this certific<br>ral director,   | 0 8            | 25. Was case referred to medical examiner?  1  Yes 2 No  | Hospital: 1 X npati   | ient 2 ER/Outpa                                       | atient 3 DOA Oth  | or  | ath <i>Check</i> only o               |                                    | ther /Case                               |  |
| ס ר        |  | T:uc           | 27. Manner of Death  | 28a. Date of Inju   | ury 28b. Tim  | ne of 28c. Injur  |   |                                       | how injury occu                    |  | //   |
| <u>0</u>   | Attendin<br>death.<br>ctor; At<br>y the fur  | atic           | 1 Natural 5 Pending 2 Accident investigation   | (Month, De  | ay 70a7/ Inje   |   | Yes 2 □No   |                                       |                                    |  |  |
| DIVISION   | tal or Attencis after death  | Certification: | 3 Suicide 6 Could not be<br>4 Homicide determined  | 28e. Place of In<br>building, e                                   | ijury - At home, farm<br>tc. (Specify)                | , street, factory, office                                       |   | 28f. Location (<br>City or To         | Street and Nurr<br>wn, State)      | nber or Rura                             | l Route Number,                                    |
|            | To the Hospital or Attending within 24 hours after death.  To the Funeral Director; Attention the funetion in by the fune  | edicai         | one)   | sician: To the best<br>ner: On the basis of<br>and manner st      | of examination and/o                                  | death occurred at the time or investigation, in my o            | pinion, death occu                                    | , and due to the<br>rred at the time, | cause(s) and n<br>date and place   | nanner as st<br>, and due to             | ated.<br>the cause(s)                              |
| )          | 10 To 7  | ×              | 29b. Signature and Little of certifier   | MD  |   | 29c. Licenson   | 958   |                                       | 29d. Date sign                     | ed (Month, L                             | Day, Year)   |
|            | 5<br>Sta   | ıtė            | 30 Name and address of person who con the control of the control o | L Sec   | death (Item 23a) (Ty                                  | rpe, Print)   | Highwo  | ay s                                  | 10 G                               | BnB                                      | urnu 2100  |
|            | Regist   |                | DEC 2 7 2005   | Marina.   | N. A.   | arti  | V   |                                       |                                    |  |  |
| υH         | MH 17 Rev 1/2  | UU1            |  |   | See.  |   |   |                                       |                                    |  |  |

|                   | Physici<br>/Medic<br>Examin  | al                  | For State Registrar  1. Decedent's Name (First, Middle, Later RASHARD THOM  4a. Facility Name (If not institution, give   | st)<br>NAS  |                           | 4b. City, Town,                                       |                       |                    | 2. Date of D<br>Month                                | <sub>Day</sub>                        |  | 3. Time of D<br>01:45                           |
|-------------------|--|---------------------|---|---|---------------------------|---|-----------------------|--------------------|--|---------------------------------------|--|---|
|                   | Funeral<br>Director  |                     | 1200 Ensor Street 5. Social Security Number 220:11:12A7   | Sex 7.Ag  | ge (In yrs. last birthday | Baltimo   | r If Und              | er 24 Hrs.<br>Min. | 8. Date of B. (Month, D                              | irth<br>lay, Year)                    | 9. Bin                                       | thplace (State or ountry)                       |
|                   | pu »   | ector               | Usual Residence of Decedent  10a. State 10b. County  MD BALIMO  | ORE   | 10c. City, Town or L      | MOWN  |                       |                    |  |                                       |  | 10d. Inside City<br>1 ☐ Yes 3                   |
|                   | permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. If item 27 is marked other than "neturel", or items 23s or 28s-f show important: if item 27 is marked other than "neturel", or items 23s or 28s-f show eny injury or other traumatic event, the Medical Exercities mental terrolling at ances.   | Funeral Director    | 11. Marital Status  | VAY  12. Was Decedent Armed Forces                                      | ?                         | 10f. Zip Code 2113 Was Decedent of If Yes, specify Cu | Hispanic (            | Origin? (Sp        | ecify Yes or N                                       |                                       | LSA  14. Race - Ame Black, Whit              | erican Indian,                                  |
| 21215-0036        | 72 hours afte<br>"neturel", or i   | <u>ک</u>            | 1   Note that the second of t |   | 16a. Dec                  | 1 Yes 2 No  | upation<br>e during m |                    | ang  | 16b. Kir                              | Specify: <b>BL</b> ind of Business           | ACK<br>Industry                                 |
|                   | is 1 end 2 should be filed within of Health and Mental Hygiene. Item 27 is marked other than other treumatic event, the Missian other ev | Be Completed        | Elementary/Secondary (0-12)  11 14 GRADE  17. Father's Name (First, Middle, Last)   | College (1-4or  | 5+) ""6.                  | LABORER   | 18. Mo                |                    | e (First, Middle                                     | a, Maiden                             | STRUCT                                       | 70N   |
| Maryiand          | id 2 should be<br>th and Mental<br>27 is marked o<br>treumatic eve   | 2                   | JERRY A. BROWN 19a. Informant's Name/Relationship ( DOROTHY WILLIAM   | Type, Print)  | 0.00                      | ing Address (Stree                                    | and Num               | nber or Rur        | THOMI<br>THOMI<br>RANDAL                             | per, City or                          |  | Zip Code)<br>21133                              |
| Baltimore,        | Pages 1 end<br>ment of Health<br>ant: If Item 27<br>iury or other ti   |                     | 20a. Method of Disposition  1 Maurial 2 Cremation 3 4 Donation 5 Other (Specification)  | Removal from State  | 20b. Place of Disp        | osition (Name of<br>ematory or other pi               | ace)                  | 12 - 10            | Date   | 20c. Lo                               | cation - City or                             | Town, State                                     |
| Ball              | permit. Pag<br>Department<br>Important: I<br>eny injury o  |                     | 21. Signature of Funeral Service Licer  | سللو  | 5                         | 2. Name and Add<br>AUGHN C. O<br>ISI BALTO.           | NATU                  | PIKE               | BAUD.  | MD 21                                 | 1229   |   |
|                   | Physician<br>/Medical<br>Examiner  |                     | 23a. Part 1. Enter he disease, or com<br>shock, or heart failure. List only<br>Immediate Cause (Final<br>disease or condition<br>resulting in death)  | a. Guns   | ine.                      | Iter the mode of dy $(s(2) + 0)$                      |                       |                    |  |                                       |  | Approximate<br>Interval Betw<br>Onset and Di    |
|                   |  | Examiner            | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events   | с   | a consequence of):        |   |                       |                    |  |                                       |  |   |
| 68760,            | ficate be executed<br>physicien and<br>as the burial-transit   | edicai              | resulting in death) Last  | Due to (or as   | a consequence of):        |   |                       | · · · · ·          |  |                                       |  |   |
| O. Box            | that the death certificated by the attending properties detached for use as  | Physician/M         | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown   | 23c. If yes, outcome<br>1 ☐ Live birth<br>4 ☐ Pregnant a<br>9 ☐ Unknown | 2 Fetat death 3           | □Ectopic pregnan □ Other (specify)                    | су                    |                    |  | 2                                     | 23d. Date of del<br>Month                    | ivery<br>Day Y                                  |
| ecords, P.        | law requires that the<br>as been signed by th<br>2 should be detache   | 5                   | Part II. Other significant conditions of  | contributing to death t   | out not resulting in the  | underlying cause g                                    | iven in Pai           | t I.               |  |                                       |  | o the cause of de                               |
| <u>~</u>          | The<br>ate h<br>page   | Completed           | 25. Was case referred to medical  |   |                           |   |                       |                    | 1 Yes  | opsy<br>ormed?<br>2 \( \sum \text{No} | 24b. Were au<br>prior to<br>death?<br>1X Yes | topsy findings av<br>completion of car<br>2□ No |
| Division of Vital | il or Attending Physicien:<br>after death.<br>Director: After this certific<br>d in by the funeral director,   | ertification; To Be | 25. Was case referred to medical examiner?  1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending 2 Accident investigation  | Hospital: 1 ☐ tnpati<br>28a. Date of Inji<br>(Month, Da                 |                           | of 28c. Inju  | ther: 4 🗆             | Nursing Ho         | h <i>Check o</i> nly<br>ome 5 ☐ Res<br>28d. Describe | idence 6                              |  | oly) Scene                                      |

within 24 hours after death.

To the Funerel Director: After this certificate completely filled in by the funeral director, pa

Certification:

State Registrar

29b. Signature and title of certifier

29c. License number

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

O.C.M.E.

December 05, 2005

no completed cause of death (Item 23a) (Type, Print)

111 Penn Street, Baltimore, Maryland 21201

1200 block GASEV ST

MILLELAH 31. Date filed (Month, Day, Year)
DEC 2 7 2005

29a. Certifier

32. Registrar's Signature

STREET

|             |  |                             | S   |  | artment of Health and M  | -  |  |
|-------------|--|-----------------------------|---|--|--|--|--|
|             |  | _                           | 1 - State<br>Registrar  | Ce   | rtificate of Death   | Reg. N   |  |
|             | Physici  | an                          | Decedent's Name (First, Middle, Last)  7  | 7  |  |  | ay Year 240 P M  |
|             | /Medic   | al                          | 4a. Facility Name (Il not institution, give stre  | homas<br>et and number)  | 4b. City, Town, or Location of Death   | 7.7.5  | 22, 2005   2 M   |
|             | Examin   | ier                         | Westminister N  | /  | 11)01 10   |  | 11 11  |
|             | Funeral  |                             | 5. Social Security Number 6. Sex  | 7. Age (In yrs. last birthday)   | If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.   | 8. Date of Birth<br>(Month, Day, Year<br>March 25, | 9. Birthplace (State or Foreign Country)                             |
|             | Director   |                             | 212-07-0074   | 2□F 90 Yrs.  | World S Day's Tool's Will.   | March 25,  | 1915 MD  |
|             | and  |                             | Usual Residence of Decedent  10a. State 10b. County   | 10c. City, Town or Lo  | ocation  | · · · · · · · · · · · · · · · · · · ·              | 10d. Inside City Limits  |
|             | Maryl<br>f sho   | Ď                           | mb Carroll  | Westm  | MINISTER   |  | 1 □ Yes 2 ☑No  |
|             | r 28a  | rec                         | 10e. Street and Number  |  | 10f. Zip Code  | 10g. C   | itizen of What Country?  |
|             | 72 hours after death with the Maryland<br>natural', or Itams 23a or 28a-f show<br>Jisal Exar. It wirmust be indiffed at  | Funeral Director            | 292 Hahn  | Rd.  | 21157  |  | USA  |
|             | r dea  | ner                         | 11. Marital Status 12.  | Was Decedent Ever in U.S. 13. Armed Forces?                              | Was Decedent of Hispanic Origin? (Spe<br>If Yes, specify Cuban, Mexican, Puerto F  | cify Yes or No-<br>Rican, etc.)                    | 14. Race - American Indian,<br>Black, White, etc.                    |
| 36          | or l   | by Fi                       | 1 Never Married 2 Married 3 Widowed 4 Divorced  | 1 ☐ Yes 2 ☐ Ño If Yes, Give Year or Dates:                               | 1 ☐ Yes 2 ☐ No Specify:  |  | Specify: White   |
| 5-0036      | 2 hour   | edt                         | 15. Decedent's Educat   | on 16a. Dece   | dent's Usual Occupation  | 16b.   | Kind of Business/Industry  |
| 215         | within 72<br>ene.<br>than na   | plet                        | (Specify only highest grade of Elementary/Secondary (0-12)  | ompleted) (Give  | kind of work done during most of workir<br>DO NOT use retired)   | ng   | ) / /  |
| 2           | ed wil   | Completed                   | 10  |  | Printer  | <i></i>  | rinting Industry   |
| nd          | be fill<br>ntal H<br>od oth  | Be                          | 17. Father's Name (First, Middle, Last)   |  |  | (First, Middle, Maide                              |  |
| Maryland    | d Mer<br>d Mer<br>narks<br>natic   | 2                           | 19a. Informant's Name/Relationship (Type,   |  | ing Address (Street and Number or Rura   | Reitet   |  |
| Z<br>Z      | nit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan cartment of Health and Mental Hygiene. cartment of Health and Mental Hygiene. cartment of Hems 23a or 28a-1 show cortent: if item 27 is marked othar than "natural", or Itams 23a or 28a-1 show injury or other traumatic event, the Medical Exar. It within the Indiffical at injury or other traumatics. |                             | Mamacet Acces   | Soughton 200   | Washing Road Was   | transfer on  | m) 2/157   |
| อ์          | t Heal   |                             | 20a. Method of Disposition  | 20b. Place of Dispo  | osition (Name of Dimatory or other place)  | ate 20c.   | ocation - City or Town, State  |
| Baltimore,  | Pages<br>lent of<br>nt: If it  |                             | 1 ☐ Burial 2 ☐ Cremation 3 ☐ Rem  `4 ☐ Donation 5 ☐ Other (Specify)                                   | oval from State  | 11 Crem tout 12/2  | 4/05 B   | 1/4 more M   |
| alti        | permit. Page<br>Department o<br>Important: If<br>any injury or<br>once.  |                             | 21. Signature of Funeral Service Licensee   | 2  | 2. Name and Address of Facility  | I FUNERA   | Home DA.   |
| <u>B</u>    | Dep<br>Impe  |                             | The Hiller  | mo 1455  | 2134 WILLOW S  | DrING R  | d. 21272   |
|             |  |                             | 23a. Part1. Enter the disease, or complicate shock, or heart failure. List only one of                | ions that caused the death. Do not en<br>cause on each line.             | ter the mode of dying, such as cardiac o   | respiratory arrest,                                | Approximate<br>Interval Between<br>Onset and Death                   |
|             | Physician  |                             | Immediate Cause (Final disease or condition resulting in death)                                       | Cerebovascu  | la accidente   |  | Iweek  |
|             | /Medical<br>Examiner   |                             | resulting in death)   | Due to (or as a consequence of):   | to King 1 1  | 2  | 254  |
|             |  | ē                           | Sequentially list conditions, if any, leading to immediate  | Due to (or as a consequence or):   | ine prining  | sens   | June -   |
|             | uted<br>d<br>ansit   | Examiner                    | if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c | Perushend Va   | menter Dise  | are  | 254  |
| ó           | ie be exec<br>ysician an<br>e burial-tr  |                             | resulting in death) Last  | Due to (or as a consequence of):   |  |  |  |
| 3760        | w requires that the death certificate be executed been signed by the attending physician and should be detached for use as the buriat-transit  | ical                        | d   | Gangrene   |  |  | 204  |
| .89 x       | requires that the death certifical<br>een signed by the attending phy<br>hould be detached for use as th   | Completed by Physician/Medi | IF FEMALE:  | If you automa of accounts  | · · · · · · · · · · · · · · · · · · ·  |  |  |
| Вох         | attend<br>for us   | ian                         | in the past 12 months?  |  | ☐Ectopic pregnancy<br>☐ Other (specify)  |  | 23d. Date of delivery  Month Day Year                                |
| 0           | the d  | ysic                        | 1 ☐ Yes 2 ☐ No<br>9 ☐ Unknown   | 9☐ Unknown   |  |  |  |
| Δ.          | s that<br>ned b<br>e deta  | y P                         | Part II. Other significant conditions contril   | outing to death but not resulting in the t                               | underlying cause given in Part I.  | 23e. Did tobacco                                   | use contribute to the cause of death?                                |
| Records,    | quire;<br>en sig<br>uld b  | ed b                        |   |  |  | 1 Yes  | 2 No 3 Probably 4 Unknown  |
| 900         | taw re<br>as be  | plet                        |   |  |  | 24a. Was an autopsy                                | 24b. Were autopsy findings available prior to completion of cause of |
| Ē           | The ate h  | E C                         |   |  |  | performed?<br>1 ☐ Yes 2 X N                        | death?   |
| Vital       | Physician: this certific   | Be                          | 25. Was case referred to medical examiner?  | a Maria  | 26. Place of Death   | (Check only one)                                   | ne din   |
| of          | 2 0 0  | 2                           | TE Tes ZENO   | pital: 1 ☐ Inpatient 2 ☐ ER/Outpatie<br>28a. Date of Injury 28b. Time of | The second secon | ne 5 Resid <i>e</i> nce<br>28d. Describe how inj   | 6 □Other (Specify)   |
| Division of | ding<br>h.<br>After<br>funer   | tion                        | 1 Natural 5 ☐ Pending   | (Month, Day Year) Injury   | Work?<br>M 1 ☐ Yes 2 ☐ No  | .co. Describe now inj                              | ary obsaired   |
| /isi        | Attanding r death. actor: After by the funer   | fica                        | 3 ☐ Suicide 6 ☐ Could not be  | 28e. Place of Injury - At home, farm, st                                 |  | 28f. Location (Street a                            | and Number or Rural Route Number,                                    |
| ē           | s after  | Certification:              | 4 Homicide  | building, etc. (Specify)   |  | City or Town, Sta                                  | te)  |
|             | To the Hospital or Attanding Ph<br>within 24 hours after death.<br>To tha Funeral Diractor: After thi<br>completely filled in by the funeral.  | cai (                       | 29a. Certifier 1 Certifying Physic (Check only 2 Medical Examine)                                     | an: To the best of my knowledge, dea                                     | th occurred at the time, date and place, a   | and due to the cause(                              | s) and manner as stated.   |
|             | the H<br>in 24<br>the F<br>nplete  | Medical                     | one)  | and manner stated.   |  |  |  |
| <b>N</b>    | Tomos  | ~                           | 29b. Signature and title of certifier   | 111  | 29c. License number  |  | late signed (Month, Day, Year)                                       |
| 1           |  |                             | John hi   | Callum ThD pleted cause of death (Item 23a) (Type                        | DAJ 443  | 10   | 4 x 2 2063   |
|             |  |                             | 30. Name and address of terson who com  | 688 PeoloRd  | Print) Westminster,  | mi) :  | 2/15-7   |
|             | Sta  | ate                         | 31. Date filed (Month, Day, Year) DEC 2 7 2005  | 32. Registrar's Signature  | 3  |  |  |
|             | Regist   |                             | DEC 2 7 2005  | British D. Appares   |  |  |  |

|   | -                | State of Maryland / Department of Health and M  1- State Registrar Certificate of Death   | 1  | 2005<br>1. No.                               | 4 747   |
|---|------------------|---|--|--|---|
|   |                  | Decedent's Name (First, Middle, Last)   | 2. Date of Death<br>Month                  | Day Year                                     | 3. Time of Death                                |
| Physicia<br>/Medic  |                  | MARLENE ELIZABETH VOLMAR  |  | 23, 2005                                     | 5:33 A M  |
| Examin  |                  | 4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death  | 4c. County of Death                        |  |   |
|   |                  | ANNE ARUNDEL MEDICAL CENTER  5. Social Security Number  6. Sex  7. Age (In yrs. last birthday)  If Under 1 Year  If Under 24 Hrs.   | 8. Date of Birth                           | ANNE ARUN                                    | nplace (State or Foreign                        |
| Funeral<br>Director   |                  | 213.34.4159  1 M 2 F K Yrs. Months Days Hours Min.  | (Month, Day, Y                             | rear) Co                                     | untry)<br>MD                                    |
| pug *   |                  | Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location   | **   |  | 10d. Inside City Limits                         |
| daryla<br>f sho   | ō                |   |  |  | 1 ☐ Yes 2 ☐ No                                  |
| r 28a-  | rect             | MD ANNE ARUNDEL GLEN BURNIE  10e. Street and Number 10f. Zip Code   | 100  | g. Citizen of What Co                        |   |
| th with   | al D             | 102 A CRAIN HWY #866 21061  |  | USA  |   |
| 13-UU30<br>172 hours after death with the Maryland<br>172 hours or Items 23a or 28a-f show<br>21cul Examinations Landilliad at  | Funeral Director | 11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  13. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto   | ecify Yes or No-<br>Rican, etc.)           | 14. Race - Ame<br>Black, White               |   |
| bours after   | by Fi            | 1 Yes 2 No Specify: 3 Widowed 4 Divorced Year or Dates:   |  | Specify:                                     | HITE  |
| 2 hou   |                  | 15 Decedent's Education 16a Decedent's Usual Occupation   | 16   | 3b. Kind of Business/                        |   |
| - c - 3   | Completed        | (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)  (Give kind of work done during most of work life. DO NOT use retired)  | ing  |  |   |
| D 0 0 1   |                  | 12 SENIOR CARE GIVER  | E (First, Middle, Ma                       | LDERCARE                                     |   |
| a d la by   | Be               | 47.77   |  | alderi Surriame)                             |   |
| Taryla 2 should the and Ment Is marked aumatics   | 2                | HOWARD W. VOLMAR  19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rura   |  | City or Town, State, 2                       | lip Code)                                       |
| 2 5 E 2 E   | 3                | LYNN MOORE 23351 ROSS STATION RD  | SEAFORD,                                   | DE 19973                                     |   |
| of Hez  |                  | 20d. Welliod of Bioposition   | Date 20                                    | oc. Location - City or                       | Town, State                                     |
| altimor   |                  | Burial 2 Cremation 3 Removal from State  Commetery, crematory or other place)  LOUDON PARK CEMETERY 12.29   | 9.2005 E                                   | BALTIMORE,                                   | MD  |
| baltimory permit. Pages : Department of t Important: if ite any injury or of  |                  | 21. Signal fee Juneral Service Licestee FINK FUNERAL HOME,  K. GREGORY FIRK MO1148 426 CRAIN HWY SW G   |  | E. MD 210                                    | 61  |
|   |                  | 23a. Part Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac shock or heart failure. List only one cause on each line.   |  |  | Approximate<br>Interval Between                 |
| Physician   |                  |   |  |  | Onset and Death                                 |
| /Medical<br>Examiner  |                  | Immediate Ca e (Final disease or condition resulting in death)  Due to (or as a consequence of):  Due to (or as a consequence of):  Atheroscleratic heart disease   |  |  |   |
| LAGITATION  | ē                | Sequentially list conditions, dairy legiting to immediate Due to for as a consequence of:   | •  |  |   |
| ted<br>nsit   |                  | cause. Enter Underlying Cause (Disease or injury  |  |  |   |
| ),<br>execu<br>in and<br>ial-tra  | Examin           | that initiated events resulting in death) Last Due to (or as a consequence of):   |  |  |   |
| . BOX b8 / bU, death certificate be executed eattending physician and id for use as the burial-transit  | cal              | d   | · · · · · · · · · · · · · · · · · · ·      |  |   |
| C 68<br>artifica<br>ing ph<br>e as tl   | Medi             | IF FEMALE:  | · · · · · · · · · · · · · · · · · · ·      |  |   |
| BOX 6 eath certif eath certif attending for use as  | Physiclan/M      | 23b. Was decedent pregnant in the past 12 months?  1 Live birth 2 Fetal death 3 Ectopic pregnancy  1 Pregnant at time of death 5 Other (specify)  |  | 23d. Date of deli<br>Month                   | very<br>Day Year                                |
| that the de ned by the s  | ysic             | 1 Yes 2 No 9 Unknown  |  |  |   |
| Kecords, P.O. The law requires that the te has been signed by the wage 2 should be detache  | by Pr            | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  | 23e. Did toba                              | cco use contribute to                        | the cause of death?                             |
| COTGS, w requires been signs should be  | ed b             | mitral value replacement.   | 1 ☐ Yes                                    | 2 2 No 3 □ Pr                                | obably 4 Unknown                                |
| aw reas bee   | plet             |   | 24a. Was an autopsy                        | 24b. Were au                                 | topsy findings available completion of cause of |
|   | Completed        |   | performe                                   | ed? death?                                   | 2□ No   |
| VITAL P   | Be (             | eyaminer?   | h (Check only one)                         |  |   |
| Of V<br>Physical this call dire   | 10               |   | me 5 Residen<br>28d. Describe how          | ce 6 Other (Spec                             | cify)   |
| DIVISION OT  I or Attanding Phy after death. Diractor: After this in by the funeral d   | tion             | 1 Natural 5 Pending (Month, Day Year) Injury Work?  | 200. Describe now                          | injury occurred                              |   |
| Attanger death  | fica             | 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office   | 28f. Location (Stre                        | et and Number or Ru                          | ral Route Number,                               |
| al or safter  | Certification:   | 4 ☐ Homicide determined building, etc. (Specify)  | City or Town,                              | Srare)                                       |   |
| UNISION OF VITA To the Hospital or Attanding Physician: within 24 hours after death. To the Funaral Diractor: After this certifical completely filled in by the funeral director, | edical (         | 29a. Certifier  (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated. | and due to the cau<br>red at the time, dat | use(s) and manner as<br>e and place, and due | stated.<br>to the cause(s)                      |
| To the within Fo the sompli   | Me               | 29b. Signature and title of certifier 29c. License number   |  | d. Date signed (Monti                        |   |
|   |                  | Stephin Clay DS8510   | 1  | 12/23/05                                     | ī.  |
| X   |                  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Stephen Dlexo AAMC.   |  |  |   |
| Sta   | ate              | 21 Data filed (Month Day Yoar) 28 Degistrate Signature  |  |  |   |
| Regist  | rar              | DEC 2 7 2005  |  |  |   |

Adam Vazquez 05-08648 d1

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend item#4a, perME, G850, 12-27-05 (Trackb and Martel Hysians)

| d                 | Τ  |  |   | State of Maryland  |                           |  |                                 |                      | ntal Hyg                         | giene                        | E.                       | 1. 171.0                                      |
|-------------------|--|--|---|--|---------------------------|--|---------------------------------|----------------------|----------------------------------|------------------------------|--------------------------|---|
|                   |  |  | 1 - State<br>Registrar  |  | Cei                       | tificate d                               | of Death                        |                      |                                  | Reg. No. U                   | J                        | 41/40   |
| Н                 | Physicia   | an   | Decedent's Name (First, Middle, Last)   |  |                           |  |                                 |                      | Date of Dea<br>Month             | Day                          | Year                     | 3. Time of Death                              |
|                   | /Medic   | al   |   | quez   |                           | 4b City Tow                              | n or Location                   |                      | Decemb                           | er 21,                       | 2005                     | 12:19 P                                       |
|                   | Examin   | ter 4a. a ging Name (If not institution, give street and number) 4b. City, Town, or Location of Death Pikesville |   |  |                           |  |                                 |                      |                                  | Balti                        |                          |   |
|                   | Funeral<br>Director  |  | 5. Social Security Number 6. Sex 114-70-8848  | 7. Age (In yrs. las  | t birthday)<br>Yrs.       | If Under 1 Y<br>Months Da                | ear If Under<br>ays Hours       | Min. M               | Date of Birth (Month, Day arch 1 | , Year)<br>, 1979            | 9. Birthr                | place (State or Foreign<br>http)<br>W York    |
|                   | D.   |  | Usual Residence of Decedent   | 100 City   | Town or Lo                |  |                                 |                      |                                  |                              | 1.                       | 10d. Inside City Limits                       |
|                   | ed at  | ò  | Maryland Baltimo  | ,  | kesvi                     |  |                                 |                      |                                  |                              |                          | 1 ☐ Yes 2 ☑ No                                |
|                   | 28a-1  | Director   | 10e. Street and Number  | 10 00.   | 10311                     | 10f. Zip Co                              | de                              |                      |                                  | 10g. Citizen of              | What Cou                 | ntry?   |
|                   | 3a or  | 0  | 3918 M'Ladies Co  | ourt   |                           |  | 21208                           |                      |                                  | Unit                         | ed S                     | tates   |
|                   | ems 2  | ner  |   | Was Decedent Ever in U.S.<br>Armed Forces?   | 13. \                     | Was Decedent<br>f Yes, specify           | of Hispanic Or<br>Cuban, Mexica | igin? (Speci         | fy Yes or No-<br>can, etc.)      | 14. Rad<br>Bla               | ce - Americk, White,     | can Indian,<br>etc.                           |
| 36                | ges 1 and 2 should be filed within 72 hours after deeth with the Maryland if of Heelth and Mental Hygiene. If Item 27 ie marked other then "naturel", or Items 23a or 28a-f ehow or other traumatic event, the Medical Examiner must be notified at  | by Funeral   | 1 ☐ Never Married 2 🛣 Married<br>3 ☐ Widowed 4 ☐ Divorced   | 1 XYes 2 No 999-<br>If Yes, Give Year or Dates: 2000                                 |                           |  | No Specify                      |                      |                                  | Specif                       | v:                       | White   |
| 21215-0036        | 2 hour   | ed   | 15. Decedent's Educ   | ation  | 16a. Deced                | ient's Usual O                           | ccupation                       |                      | 1                                | 16b. Kind of B               |                          |   |
| 215               | within 72<br>ene.<br>then "na  | plet   | (Specify only highest grade<br>Elementary/Secondary (0-12)  | Completed) College (1-4or 5+)  |                           |  | one during mos<br>etired)       | st of warking        | '                                | Balti                        |                          |   |
|                   | filed wil<br>Hygien<br>other th  | Completed  | 12 yrs.   |  | P                         | olice O                                  |                                 |                      |                                  |                              |                          | partment                                      |
| Maryland          | 2 should be filed within and Mental Hygiene. Is marked other than sumatic event, the Mental to Mental than the Mental to Mental than the Mental to Mental than Men | Be   | 17. Father's Name (First, Middle, Last)  Francisco Vaz  | zguez  |                           |  |                                 | ers Name (<br>illian |                                  | Maiden Sumar<br>nchez        | ne)                      |   |
| Z                 | should be fand Mental I  | ဥ  | 19a. Informant's Name/Relationship (Type  |  | 19b. Mailir               | ng Address (St                           |                                 |                      |                                  | r, City or Town,             | State, Zip               | Code)   |
|                   | 1 and 2 s<br>Heelth ar<br>em 27 le   |  | Mrs. Chemise M. Vaz   |  | 313                       | 57th 9                                   | Street                          | Broo                 | oklyn,                           | New Yor                      | ^k 1                     | 1220  |
| ore,              | as 1 a of Hee  |  | 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ R   | con  | ce of Dispo               | sition (Name o                           | r place)                        | Dat                  |                                  | 20c. Location                |                          |   |
| Ĕ                 | Peges<br>ment of l   |  | 4 □Donation 5 □Other (Specify)  | Gree   |                           | d Cemet                                  | ery 1                           | 12/28/               | 2005                             | Brookly                      |                          |   |
| Baltimore,        | permit. Peges 1 and 3<br>Department of Heelth<br>Important: if Item 27<br>eny Injury or other tr<br>Once.  |  | 21. Signature of Funeral Service License  | Michael E. Canap   | op <sup>22</sup>          |  | ddress of Facil<br>rd J. R      | DESCRIPTION IN       | Inc.                             | 5305 H                       |                          | d Road<br>Md. 21214                           |
|                   |  |  | 23a. Part1. Enter the disease, or compleshock, or heart failure. List only on   | cations that caused the death. e cause on each line.                                 | Do not ent                | er the mode of                           | dying, such as                  | cardiac or i         | respiratory ar                   | rest,                        |                          | Approximate<br>Interval Between               |
|                   | Physician  |  | Immediate Cause (Final disease or condition   | Multiple 9   | what                      | -Won                                     | -ds                             |                      |                                  |                              |                          | Onset and Death                               |
|                   | /Medical<br>Examiner   |  | resulting in death)   | Due to (or as a conseque   | nce of):                  |  |                                 |                      |                                  |                              |                          |   |
|                   |  | er   | Sequentially list conditions, if any, leading to immediate  | Due to (ur as a conseque   | noe offy:                 |  |                                 |                      |                                  |                              |                          |   |
|                   | cuted  | Examiner   | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events |  |                           |  |                                 |                      |                                  |                              |                          |   |
| 90,               | cate be executed<br>obysician and<br>the burial-transit  | EX   | resulting in death) Last  | Due to (or as a conseque   | nce of):                  |  |                                 |                      |                                  |                              |                          |   |
| 8760,             | physic<br>physic<br>the b  | dical  | d   |  |                           |  |                                 |                      |                                  |                              |                          |   |
| Box 6             | leath certific<br>attending p  | √/Me   | IF FEMALE:<br>23b. Was decedent pregnant  | 3c. If yes, outcome of pregnance   |                           |  |                                 |                      |                                  | 23d. Da                      | te of deliv              | ery   |
|                   | death<br>e atte  | Physician/M  | in the past 12 months? 1 ☐ Yes 2 ☐ No   | 1 ☐ Live birth 2 ☐ Fetal d<br>4 ☐ Pregnant at time of dea                            |                           | ]Ectopic pregn<br>] Other <i>(specif</i> |                                 |                      |                                  | Mo                           | onth                     | Day Year                                      |
| P.O.              | that the de<br>ned by the a<br>detached t  | Phys   | 9 Unknown   | 9□ Unknown   |                           |  |                                 |                      |                                  |                              |                          |   |
| Records,          | sigr<br>Sigr   | þ  | Part II. Other significant conditions con   | tributing to death but not result  | ing in the u              | nderlying caus                           | e given in Part                 | l.                   |                                  | obacco use con<br>⁄es 2 □ No | tribute to t<br>3 🗌 Prot | he cause of death?<br>pably 4 MUnknown        |
| eco               | law reques been 2 should   | Completed  |   |  |                           |  |                                 |                      | 24a. Was                         |                              | prior to co              | ppsy findings available impletion of cause of |
| H                 | The<br>cete h  | Соп  |   |  |                           |  |                                 |                      | perfo                            | rmed?<br>2□ No               | death?<br>1 X Yes        | 2□ No   |
| Vita              | Physician: The lav<br>r this certificete hes<br>ral director, page 2   | Be   | 25. Was case referred to medical examiner?  | ospital:   |                           |  | Othor                           |                      | Check only o                     |                              |                          |   |
| þ                 | Phys<br>r this<br>ral dii  | To   | 1 X Yes 2 No 127. Manner of Death   | 28a. Date of Injury 2  | P/Outpatier<br>8b. Time o |  | Injury at Work?                 |                      | d. Describe h                    | dence 6 QOth                 | red                      | y) scene                                      |
| ion               | Attending<br>ir death.<br>ector: After<br>by the fune  | atlor  | 1 ☐Natural 5 ☐ Pending 2 ☐ Accident investigation   | (Month, Day Year)  | (206/                     | M  | Work?                           | (No                  | Serby                            | it shall                     | -                        |   |
| Division of Vital | r Atta   | Certification;   | 3 ☐ Suicide 6 ☐ Could not be determined   | 28e. Place of Injury - At hom<br>building, etc. (Specify)                            |                           |  | fice                            | 28                   | f. Location (S<br>City or Tox    | Street and Numi              | per or Run               | al Route Number,                              |
| ā                 | ital or<br>urs afte<br>ral Dir<br>lled in  |  | ^   |  | ho                        | ne                                       |                                 | ŕ                    | kesvill                          | , May/                       | ed                       | -active lower                                 |
|                   | To the Hospital or Attanding Physician: The I within 24 hours after death.  To the Funeral Director: After this certificete he completely filled in by the funeral director, page  | edical   |   | sician: To the best of my knowledge:  On the basis of examination and manner stated. |                           |  |                                 |                      |                                  |                              |                          |   |
|                   | To the within 2 To the complex   | Med  | 29b. Signature and title of certifier   | and manner stated.   |                           | 29c. Li                                  | cense number                    |                      |                                  | 29d. Date signe              | ed (Month,               | Day, Year)                                    |
|                   |  |  | 16.1.11   | Y  |                           | OCI                                      | MF.                             |                      |                                  | Decembe                      | r 22                     | 2005  |
| -                 | 24+1   |  | 30. Name and address of person who co   | mpleted cause of death (Item 2   | 23a) (Type,               |  | 111                             |                      |                                  | DECEMBE                      | L 44                     | , 2007  |
| 1                 | *  |  | THE UDDREMIKING   | -  |                           | 111 Pe                                   | enn Str                         | eet, I               | Baltimo                          | ore, Mar                     | ylan                     | d 21201                                       |
|                   | Sta<br>Regist  |  | 31. Date filed (Month, Day, Year) DEC 2 7 200   | 32 Registrar's Signatu   | To do                     | and I                                    |                                 |                      |                                  |                              |                          |   |

|                            |  |                  | For<br>Stata<br>Registrar   | State of Maryland   | •   | nt of Health and te of Death                                 |  | 2005<br>1. No.                                  | 41749  |  |  |  |  |       |  |  |   |      |
|----------------------------|--|------------------|---|---|---|--|--|---|--|--|--|--|--|-------|--|--|---|------|
| 8                          | Physici  | an               | Decedent's Name (First, Middle, Last,   | Conclination  | (1)   | 1  | 2. Date of Death<br>Month  | Day Year  | 3. Time of Death   |  |  |  |  |       |  |  |   |      |
|                            | /Medic<br>Examin   | ai               | 4a. Facility Name (If not institution, give   | street and number)  | ,   | , Town, or Location of Dea                                   |  | 4c. County of Death                             |  |  |  |  |  |       |  |  |   |      |
|                            | Funeral<br>Director  |                  | Saint Joseph M<br>5. Social Security Number 6. Sec<br>212-38-1049 19  |   |   | TOWS ( or 1 Year   If Under 24 Hrs Days   Hours   Min        | 8. Date of Birth   | Balti 9. Birth                                  | place (State or Foreign ntry)                            |  |  |  |  |       |  |  |   |      |
|                            | Maryland<br>a-f show   | tor              | Usual Residence of Decedent  10a. State  10b. County  RALII   | 10c. City, T  | own or Location                                       | nix  |  |   | 10d. Inside City Limits 1 ☐ Yes 2 No                     |  |  |  |  |       |  |  |   |      |
|                            | sath with the<br>s 23s or 28<br>must be not  | Funeral Director | 10e. Street and Number<br>2401 Carroll  | Mill Rd.  |   | 21131  |  | Citizen of What Cou                             |  |  |  |  |  |       |  |  |   |      |
| 9036                       | ours after de<br>rei', or Item<br>Exeminar   | by               | 11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced   | 12. Was Decedent Ever in U.S.<br>Amed Forces?<br>1 ☐ Yes 2 ☐ No<br>If Yes, Give<br>Year or Dates:       | 13. Was Dece  | dent of Hispanic Origin? (secify Cuban, Mexican, Puel        | to Rican, etc.)  | 14. Race - Ameri<br>Black, White                |  |  |  |  |  |       |  |  |   |      |
| 21215-0036                 | ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If Item 27 is marked other than "naturel", or Items 23a or 28a-f show or other traumatic event, the Modical Examinar must be notified at                                  | Completed        | 15. Decedent's Edu<br>(Specify only highest grad  | cation 1 completed) College (1-4or 5+)  | 6a. Decedent's Usi<br>(Give kind of w<br>life. DO NOT | ork done during most of was retired)                         | rking  | Sb. Kind of Business/Ir                         | Technologij  |  |  |  |  |       |  |  |   |      |
| Maryland                   | 2 should be fit and Mental His marked oth sumatic even   | To Be            | 17. Father's Name (First, Middle, Last)  19a. Informant's Name/Relationship (Ty   | rtz<br>pe, Print)   | 19b. Mailing Ad res                                   | 18. Mother's Na  Ada s (Street and Number or R               | me (First, Middle, Ma<br>L / L / L<br>u al Route Nember, (                   | wheth &   | NSOR:  |  |  |  |  |       |  |  |   |      |
|                            | Pages 1 and 2<br>nent of Health a<br>int: if item 27 is<br>iry or other trau   |                  | Parbara A. U<br>20a. Method of Disposition<br>1 Burial 2 Cremation 3 F  | come  | e of Disposition (Na<br>etery, crematory or           | me of other place)   | d. Phoe  | DC. Location - City or T                        | 213/,<br>own, State                                      |  |  |  |  |       |  |  |   |      |
| Baltimore,                 | permit. Pages 1 and Department of Heali Important: If Item 2 eny injury or other once.   |                  | 4 □Donation 5 □Other (Specify) 21. Signature of Funeral Service License   | Seviotry  | 22. Name a  | DLALTELNA  | TIVESFUL   | ERAL + CR                                       | MO ZIO93,<br>EMATINE                                     |  |  |  |  |       |  |  |   |      |
|                            | Physician<br>/Medical  |                  | 23a. Part1. Enter the disease, or compl<br>shock, or heart failure. List only of<br>Immediate Cause (Final<br>disease or condition<br>resulting in death) | dations that caused the death. Decause on each line.  SUDDEN CARD:  Due to (or as a consequent          | IAC ARRE  | _  | c or respiratory arres   |   | Approximate Interval Between Onset and Death             |  |  |  |  |       |  |  |   |      |
| 8760,                      | ircate be executed physician and physician and s the burial-transit  | Ical Examiner    |   |   |   |  | dical  | dlcal   | dlcal  |  |  | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | ARTERIOSCLES  Due to (or as a consequent  Due to (or as a consequent | ROSIS |  |  | Y | EARS |
| P.O. Box 6                 | To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending p completely filled in by the funeral director, page 2 should be detached for use as | by Physician/Med | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown  | 3c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de: 4 ☐ Pregnant at time of death 9 ☐ Unknown | ath 3 Ectopic p                                       |  |  | 23d. Date of delive Month                       | ery<br>Day Year  |  |  |  |  |       |  |  |   |      |
| ords, P.                   | w requires that is been signed by should be deta   | ted by Ph        | Part II. Other significent conditions cor   | ntributing to death but not resultin  | ng in the underlying                                  | cause given in Part I.                                       |  | cco use contribute to l                         | a. dl  |  |  |  |  |       |  |  |   |      |
| ai Reco                    | n: The law r<br>ficate has be<br>r. page 2 sh  | Completed        | HYPERTENSION  |   |   |  | 24a. Was an<br>autopsy<br>performe<br>1 Yes 2                                | 24b. Were autoprior to codeath?                 | opsy lindings available<br>impletion of cause of<br>2DNo |  |  |  |  |       |  |  |   |      |
| Division of Vital Records, | To the Hospital or Attending Physician: The Is within 24 hours after death.  To the Funeral Director: After this certificate ha completely filled in by the funeral director, page?  | ıtlon; To Be     | 25. Was case referred to medical examiner?  1  Yes 2 No  27. Manner of Death 1  Natural 5  Pending 2  Accident investigation                              | / ¥   | /Outpatient 3 D b. Time of Injury                     | Other  | ath <i>(Check only</i> on <b>é)</b><br>Home 5 ☐ Residen<br>28d. Describe how | ce 6 Other (Special injury occurred             | (y)  |  |  |  |  |       |  |  |   |      |
| Divisi                     | tal or Atter<br>rs after dea<br>al Director<br>led in by the   | Certification:   | 3 Suicide 6 Could not be determined   | 28e. Place of Injury - At home building, etc. (Specify)   |   |  | City or Town,  | ·   |  |  |  |  |  |       |  |  |   |      |
|                            | ne Hospi<br>n 24 hou<br>se Funei   | Medical          | 29a. Certifier 1 Certifying Physical (Check only one) 2 Medical Examination   | sician: To the best of my knowled<br>ner: On the basis of examination<br>and manner stated.             | dge, death occurred<br>and/or investigation           | f at the time, date and place<br>n, in my opinion, death occ | e, and due to the cau<br>urred at the time, date                             | se(s) and manner as s<br>a and place, and due t | stated.<br>o the cause(s)                                |  |  |  |  |       |  |  |   |      |
| •                          | To the within To the comp  | W                | 29b. Signature and title of certifier   | no  | I   | c. License number  | 290  | Date signed (Month,                             |  |  |  |  |  |       |  |  |   |      |
|                            | Sta<br>Registr   |                  | 30. Name and address of person who of FARTICE CZARNEC 31. Date filed (Month, Day, Year)  DEC 2 7 20   | K.T. M. D. 760<br>32 Registrar's Signature  | AL OSLE   | R DRIVE TOU  | JSON, MAF  | RYLAND 21                                       | 204  |  |  |  |  |       |  |  |   |      |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

|            |  |                  | For<br>State<br>Registrar  | State of Maryland /  | Certificate of Dea  |  | 1yglene<br>Reg. No. 05 41750   |
|------------|--|------------------|--|--|---|--|--|
|            | Physici  |                  | 1. Decedent's Name (First, Middle, Las   | re Wilson  | )   | 2. Date of Month   | Death Say Yeer SaySA. M  |
|            | /Medic<br>Examin<br>Funeral<br>Director  |                  | 4a. Faglity Name (If not institution, give   | sing Center  |   | ille   | Birth Day, Year)  9. Birthplace (State or Foreign Country)                                     |
|            | show   | or               | Usuel Residence of Decedent  10a. State 10b. County  |  | wn or Location  |  | 10d. Inside City Limits 1 ☐ Yes 2 ☑ No   |
|            | death with the Maryland<br>ms 23a or 28a-f show<br>Frinst be restlined at  | Funeral Director | 10e. Street and Number 5721 Camo   | Λ  | (atons Ville<br>104. Zip Code   | )a&  | 10g. Citizen of What Country?  |
| 980        | iges 1 and 2 should be filed within 72 hours after death with the Marylar in of Health and Mandal Hygiene.  If it item 27 is marked althythan "natural, or Itams 23a or 28a-1 show it it item 27 is marked than "natural, or Itams 20a or 28a-1 show or other traumatic evant. It is Medical Examinating in Italified at | by               | 11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  | 12. Was Decedent Ever in U.S. Armed Forces?  1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:                    | 13. Was Decedent of Hispani<br>If Yes, specify Cuban, Me                                      | ic Origin? (Specify Yes or exican, Puerto Rican, etc.)     | No- 14. Race - American Indian, Black, White, etc.  Specify:                                   |
| 21215-0036 | d within 72 ho<br>giene.<br>ir than "naturi<br>ir e Medical i  | Completed        | 15. Decedent's Ed<br>(Specify only highest gra<br>Elementary/Secondary (0-12)  | ucation 16 to completed) College (1-4or 5+)  | a. Decedent's Usual Occupation<br>(Give kind of work done during<br>life. DO NOT use retired) | most of working  | 16b. Kind of Business/Industry   |
| Maryland   | should be filed within nd Mental Hygiene. marked othar than Imatic evant, Ire Me   | To Be C          | 17. Father's Name (First, Middle, Last)  UN KNOWN  | Snow.  | ) 18. M   | Mother's Name (First, Middle NER                           | dle, Maiden Sumame)  (UNKNOWN)   |
|            | tand 2 sho<br>Health and<br>tam 27 is m  |                  | 19a. Informant's Name/Relationship (7  | - daughter 5   | 1434 Park Heic  | fumber or Rural Route Nur<br>AND AND<br>Date               | mbar, City or Town, State, Zip Code)    Kestille MD Z1Z08   2 c. Location - Oty or Town, State |
| Baltimore, | t. Part<br>rtmer<br>rtant  |                  | 1 ☐ Burial 2 Cremation 3 ☐ '4 ☐ Donation 5 ☐ Other (Specify  21. Signature of Funeral Service   0+n  | Evanst   | ony, crematory organologice)  Constitution (NGAC) -  22. Name an Address of E                 | 12/27/05   | Forest HI MO   |
| ă I        | Depariment Deparement Impo   |                  | 23a. Pari 1. Enter the disease, or compshock, or heart failure. List only  | JOUNTING  Street in the caused the death. Do   | ACEFUL ALTER<br>o not enter the mode of dying, suc  | natives Func   | 400+Cremotian Conta  |
| 18         | Priysician<br>/Medical<br>Examiner   |                  | Immediate Cause (Final disease or condition resulting in death)  | a  | ive Henry   | + Jeall  | Interval Between Onset and Death   |
| 68760,     | rtificate be executed<br>1g physician and<br>as the burial-transif   | edical Examiner  | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | Due to (or as a consequence  Due to (or as a consequence  d.   | De month  | a .  |  |
| .O. Box    | the death certif<br>y the attending<br>iched for use as  | Physiclan/Me     | IF FEMALE: 23b. Was decedent pregnant in the past 12 moorts? 1 □ Yes 2 □ No 9 □ Unknown  | 23c. If yes, outcome of pregnancy<br>1□Live birth 2□Fetal deal<br>4□Pregnant at time of death<br>9□Unknown | th 3 □Ectopic pregnancy<br>5 □ Other (specify)  |  | 23d. Date of delivery  Month Day Year  |
| rds, P.    | sign<br>d be   | by               | Part II. Other significant conditions of   | ontributing to death but not resulting   | in the underlying cause given in F  |  | id tobacco use contribute to the cause of death?  ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown        |
|            | The law<br>ate has b<br>page 2 sh  | Completed        |  |  |   |  | prior to completion of cause of death?   |
| Vital      | Physician: Th<br>this certificate<br>ral director, pag   | To Be            | 25. Was case referred to medical examiner?  1  Yes 2 No  | Hospital: 1 ☐ Inpatient 2 ☐ ER/0   | Other   | Place of Death (Check on                                   | ly one) sidence 6 □Other (Specify)   |
|            | ng<br>fter<br>ne   |                  | 27. Manner of Death  1 Natural 5 Pending 2 Accident investigation  | 28a. Date of Injury<br>(Month, Day Year)   | . Time of Injury at Work?  M 1 □ Yes  | 28d. Describ   | be how injury occurred   |
| Division   | To the Hospital or Attandii<br>within 24 hours after death.<br>To tha Funaral Director: A<br>completely filled in by the fu  | Certification:   | 3 Suicide 6 Could not be determined  | building, etc. (Specify)   |   | City or  | n (Street and Number or Rural Route Number,<br>Town, State)                                    |
|            | he Host<br>in 24 hoi<br>ha Funa<br>oletely fi  | edical           | 29a. Certifier (Check only one)  1 Certifying Ph 2 Medical Exam  | /sician: To the best of my knowledginer: On the basis of examination a and manner stated.                  | ge, death occurred at the time, da<br>and/or investigation, in my opinion                     | te and place, and due to to<br>, death occurred at the tim | he cause(s) and manner as stated. he, date and place, and due to the cause(s)                  |
|            | To t<br>To t   | Σ                | 29b. Signature and title of certifier  | Cemm in  | 29c. License num  |  | December 27, 2005  |
|            | i}   |                  | 30. Name and address of paramy or  | completed cause of death (Item 23a   | (Type, Print)   | -thos  | Decompose 27, 2008<br>Marshall 21208   |
|            | Sta  |                  | 31. Date filed (Month, Day, Year)  | 32 Registrar's Signature   | Sporte  |  |  |

Wilson, Essie

|   |                      | . For   | iease i                        | State of M   |               |                                  |                         |                             |  | •                             |                          |                                       | 1. 1 -                               | 751                          |
|---|----------------------|---|--------------------------------|--|---------------|----------------------------------|-------------------------|-----------------------------|--|-------------------------------|--------------------------|---------------------------------------|--------------------------------------|------------------------------|
|   |                      | 1 - State<br>Registrar  |                                |  |               | Cei                              | tifica                  | te of L                     | Death  |                               | Reg. N                   | . 000                                 | 4                                    | 7 3 1                        |
| Phys<br>/Me   | iciar<br>dica        |   | Middle, Last)<br>Ward          |  |               |                                  |                         |                             |  | 2. Date of Month Decem        | ber D                    | <sup>ay</sup> 22 2005                 | 5 11:                                | :40 PM                       |
| Exar  | ninei                |   | _                              |  | )             |                                  | 4b. City                |                             | Location of Dea<br>1thicum                         | th                            | 4                        | c. County of Dear<br>Anne Ar          |                                      |                              |
| Funer   | al                   | 406 Applega<br>5. Social Security Number  | 6. Sex                         | 7. A   | ge (In yrs.   | last birthday)                   |                         | r 1 Year                    | If Under 24 Hrs                                    |                               | Birth                    |                                       |                                      | ate or Foreign               |
| Direct  |                      | 216-36-8916 Usual Residence of Decede   |                                | M 2XIF   |               | 88 Yrs.                          | Months                  | Days                        | Hours Min  | Jan.                          | Day, Yөа<br>06           | 1917                                  | Engla                                | nd                           |
| Marylan<br>a-fehow  | i,                   | Maryland A  | nne Arı                        | undel  | 10c. Cit      | y, Town or Lo                    | cation                  | G1                          | en Burni   | е                             |                          |                                       |                                      | e City Limits<br>Yes 2 X No  |
| with the  | O. P.                | 10e. Street and Number  |                                |  |               |                                  | 10f. Z                  | p Code                      | 04.064   |                               | 10g. C                   | itizen of What Co                     |                                      |                              |
| leath v   | 9                    | 7629 0 Dani   |                                | 2. Was Decedent  | Ever in U.    | .S.   13. \                      | Was Dec                 | edent of Hi                 | 21061  | Specify Yes or                | No-                      | USA<br>14. Race - Ame                 |                                      | n,                           |
| if e, INTALY INTELLIBY A LATIONOSO s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. If Health and Mental Hygiene offer transfer other than "natural; or itame 23a or 28a-f ehow other traumatic event, tha Medical Examinar must be notified at  | by Europeal Director |   | Married                        | Armed Forces  1 Yes 2  If Yes, Give Year or Dates.               | ?             |                                  | f Yes, spi<br>1 ☐ Yes   |                             | spanic Origin? (\$<br>n, Mexican, Puer<br>Specify: | to Rican, etc.)               |                          | Black, Whit                           |                                      |                              |
| 72 ho<br>72 ho<br>natur   | Completed            | 15. De<br>(Specify only   | edent's Educ                   | ation<br>completed)  |               | 16a. Deced                       | ient's Usi              | al Occupa                   | ition<br>Juring most of wo                         | rking                         | 16b.                     | Kind of Business                      | Industry                             |                              |
| within the  | i e                  | Elementary/Secondary (0   |                                | College (1-4or   | 5+)           | life. I                          |                         |                             | luring most of wo                                  | 3                             | ,                        | Househo                               | 1.d                                  |                              |
| filled v<br>Hygie<br>ther i   | 2                    | 17. Father's Name (First, M   | ddle, Last)                    |  |               |                                  | ПОП                     | emake                       | 18. Mother's Na                                    | me (First, Midd               | dle, Maide               |                                       | Tu                                   |                              |
| should be should be ind Mental I  | T G G                |   |                                | eridge   |               |                                  |                         |                             | Alice  | Н                             | lasti                    | ngs                                   |                                      |                              |
| IVICITY  nd 2 shouth and N  27 is main  |                      | 19a. Informant's Name/Rel<br>Jennifer Wa  |                                | OB, Print)<br>(Daughte   | r)            |                                  | _                       |                             |  |                               |                          | or Town, State, 2                     |                                      |                              |
| es 1 a of Height  |                      | 20a. Method of Disposition<br>1 ☐ Burial 2 🖾 Crem   | ution 2 🗆 R                    | amount from State  | 20b. P        | Place of Dispo                   | sition (Na              | ime of<br>other place       | e) Doc   | Date 2.4                      | 20c. I                   | ocation - City or                     | Town, Stat                           | 9                            |
| DESILEMBLE Demit: Pages Department of mportant: If it iny injury or o   |                      | 4 Donation 5 Ot   | ner (Specify)                  |  |               | cro Cre                          |                         | _                           | nc bec   | 24                            |                          | timore,                               |                                      |                              |
| Datumore, permit. Pages 1 an Department of Hear important: if item 2 any injury or other  | SUCE                 | 21. Signature of Funeral S  | rvice Cicerise                 | et ]   |               | 22                               |                         |                             | s of Facility<br>Intain R                          |                               |                          | Funera<br>na, MD 2                    |                                      | е, Р.А.                      |
| Physicia<br>/Medic  | al                   | 23a. Part1. Enter the nisea<br>shock, or heart fail re<br>Immediate Cause (Final<br>disease or condition<br>resulting in death) | se, or complic<br>List only on | cations that cause<br>e cause on each t<br>Dur to (or as         | ine.<br>IEN   | TIA                              | er the mo               | de of dying                 | g, such as cardia                                  | c or respiratory              | arrest,                  |                                       |                                      | mate<br>Between<br>and Death |
| It out to be executed with the best executed with the burial-transit with the | Cal Examiner         |   |                                | Due to (or as  |               |                                  |                         |                             |  |                               |                          |                                       |                                      |                              |
| I NECOLUS, T.O. BOX 600/<br>The law requires that the death certificate<br>the has been signed by the ettending phys<br>aage 2 should be detached for use as the  | Physician/Medi       | IF FEMALE: 23b. Was decedent pregna in the past 12 months 1 □ Yes 2 □ No 9 □ Unknown  | nt {                           | 3c. If yes, outcome<br>1 Live birth<br>4 Pregnant a<br>9 Unknown | 2 Feta        | Ideath 3                         | Ectopic  <br>Other (s   | pregnancy                   |  |                               |                          | 23d. Date of del<br>Month             | ivery<br>Day                         | Year                         |
| s that t<br>ned by  |                      |   |                                |  |               |                                  | nderlying               | cause give                  | ın in Part Į.                                      | 23e. Di                       | d tobacco                | use contribute to                     | the cause                            | of death?                    |
| law requires as been sign   | 4                    | AORTIC  | /ALVI                          | ERTE   | NOI.          | 18                               |                         |                             |  | 1[                            | ]Yes a                   | 2⊠No 3□Pr                             | obably 4                             | □Unknown                     |
| The law or<br>rate has be<br>page 2 sho   | Completed by         |   |                                |  |               |                                  |                         |                             |  | 24a. W<br>au<br>pe<br>1 🗆 Yes | topsy<br>normed?         | death?                                | itopsy findii<br>completion<br>2  No | ngs available<br>of cause of |
| VICAL ilcian: 1 certifical rector, p  | a                    | examiner?   |                                | ospital:   |               |                                  | _                       | Othe                        | 26. Place of De                                    |                               |                          |                                       | $\sim$                               | 11 .                         |
| Phys<br>r this<br>aral dil  | F                    |   |                                | 28a. Date of Inj   | ury           | ER/Outpatier<br>28b. Time of     |                         | OA 28c. Injury<br>Work      | 4   Nursing i                                      | dome 5 Re                     |                          | 6 Other (Speury occurred              | city) Day                            | guilers                      |
| Attending at death.  ector: Alte by the fune  | 1                    | 1 Accident 5 ☐ I  | ending<br>nvestigation         | (Month, Di   | ay Year)      | Injury                           | м                       |                             | t?<br>Yes 2 ∐No                                    |                               |                          | ,                                     |                                      |                              |
| UNISION OF VITAL THE PROPRIES TO THE HAW WITHIN 24 hours after death. To the Funeral Director: After this certificate has completely filled in by his funeral director, page 2.   | Certification.       | 3 ☐ Suicide 6 ☐ 0<br>4 ☐ Homicide   | could not be<br>etermined      | 28e. Place of Inbuilding, e                                      | njury - At ho | ome, farm, str                   | eet, facto              | ry, office                  |  |                               | (Street a<br>Town, Sta   | and Number or Ru<br>te)               | ıral Route I                         | Vumber,                      |
| ne Hospit<br>n 24 hours<br>ne Funera<br>sletely fille   | ) leallo             |   | rtifying Phys<br>dical Examir  | ician: To the besi<br>ler: On the basis of<br>and manner s       | of examina    | wiedge, death<br>ition and/or in | n occurre<br>vestigatio | d at the tim<br>n, in my op | e, date and plac<br>pinion, death occ              | e, and due to the time        | ne cause(<br>le, date ar | s) and manner as<br>nd place, and due | stated.<br>to the cau                | se(s)                        |
| To th<br>To th  | N                    |   | ertifier                       |  |               |                                  |                         | c. License                  |  |                               | 1                        | ate signed (Mont                      |                                      | ar)                          |
| 3   |                      | ) /vsn  | 8                              | ms   |               |                                  | 1                       | 57                          | 531  |                               | 12                       | -23-2                                 | 005                                  |                              |
| /   |                      | 30. Name and address of   | on who co                      | mpleted cause of   | death (Iten   | n 23a) (Type,                    | Print)                  | 1                           | 0  | . 0                           | mi                       | lersin                                | 16 00                                | 14.                          |
| 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1   | State                | 01 0 1 11 1 11 11 11  | Year                           | 2. Regist  | trar's Signa  | iture L                          | 0_/                     | wy                          | mut  | 204)                          | , , n C                  |                                       | 179                                  | 11111                        |
| A POLITY  | istrar               | ACC   | 2005                           | Reader.  | . K           | A 34                             |                         |                             |  |                               |                          |                                       |                                      |                              |

|                |   |                      | For<br>State<br>Registrar   | State of Mar   | -                                       | artment of He                                |                                | lental Hygie                            | 71115                               | 41752   |
|----------------|---|----------------------|---|--|---|--|--------------------------------|---|-------------------------------------|---|
|                |   |                      | Decedent's Name (First, Middle, Last  | 1)   |   |  |                                | 2. Date of Death                        |                                     | 3. Time of Death                                |
|                | Physici   |                      | LEE   | T.7 A T  | TKINS                                   | CD   |                                | Month<br>December                       | 20 2005                             | 2:45 p M  |
|                | /Medic  |                      | 4a. Facility Name (If not institution, give   |  | TKTN2                                   | 4b. City, Town, or                           | Location of Death              | DCCCIIIVE                               | 4c. County of Deeth                 | 1   |
|                | Examin  | ei                   | 1 Linda Lane  |  |   | Severna                                      | Park                           |   | Anne Aru                            | ndel  |
| 94             | Funeral   |                      | 5. Social Security Number 6. Se   |  | (In yrs. last birthday)                 | If Under 1 Year<br>Months Days               | If Under 24 Hrs.<br>Hours Min. | 8. Date of Birth<br>(Month, Day, Yo     | 9. Birth                            | nplece (State or Foreign untry)                 |
|                | Director  |                      | 167-18-0290   | 27M 2□F  | 84 Yrs.                                 | Months Days                                  | Hours Will.                    | Feb. 6.1                                |                                     | nsylvania                                       |
|                | 2   |                      | Usuel Residence of Decedent   |  | IOc. City, Town or Lo                   | estina                                       |                                |   |                                     | 10d. Inside City Limits                         |
|                | show  | _                    | 10a. State 10b. County  |  | •                                       |  |                                |   |                                     | 1 ☐ Yes 2 ☑ No                                  |
|                | Me M<br>8a-f  | Director             | Maryland Anne Ar  | undel  | Severna I                               | Park<br>10f. Zip Code                        |                                | 100                                     | Citizen of What Co                  | intar?  |
|                | with the  | E C                  | 10e. Street and Number  |  |   | Tor. 2ip Code                                |                                | log                                     | Chizen of What Co                   | anti y r  |
|                | s 23  | erai                 | 1 Linda Lane  | 12. Was Decedent Ev  | ver in U.S. 13                          | Was Decedent of His                          | spanic Origin? (Sp             | acify Yes or No-                        | U.S.A                               | ican Indian.                                    |
|                | ltem<br>Item  | Funeral              | 1 Never Married 2 Married   | Armed Forces?<br>1 ☐ Yes 2 ☐ No  |   | Was Decedent of His<br>If Yes, specify Cubar | , Mexican, Puerto              | Rican, etc.)                            | Black, White                        | o, etc.   |
| 36             | urs af  | by                   | 3 ☐ Widowed 4 ☐ Divorced  | If Yes, Give<br>Year or Dates:   |   | 1 ☐ Yes 2 ☑ No                               | Specify:                       |   | Specify:                            | /bite   |
| 21215-0036     | 72 hours after death with the Maryland<br>naturel', or items 23a or 28s-f show<br>deal Examinet must be natified at   | ted                  | 15. Decedent's Ed   |  | 16a. Dece                               | dent's Usual Occupa                          | tion                           | 16                                      | b. Kind of Business/l               |   |
| 215            | within 7<br>ene.<br>than "n   | Completed            | (Specify only highest grade<br>Elementary/Secondary (0-12)  | College (1-4or 5+  | life.                                   | DO NOT use retired)                          |                                | ii g                                    |                                     |   |
| 21             | d wit<br>giene<br>er thu  | NO.                  | 12  | N/A  |   | Machinis                                     |                                |   | Procter &                           | Gamble  |
| nd             | al Hygid<br>d other   | Be                   | 17. Father's Name (First, Middle, Last)   |  |   |  | 18. Mother's Name              | e (First, Middle, Ma                    | iden Sumame)                        |   |
| <u>y</u>       | 2 should be filed within 72 hours after death w<br>and Mental Hygiene.<br>Is marked other than "naturel", or iteme 23a<br>raumatic event, in W. urel Examines mash  | 2                    | Lee   |  | Watkins                                 |  | Mildred                        |   |                                     | odes  |
| Maryland       | and te m  | 1                    | 19a. Informant's Name/Relationship (7   | ype, Print)  | 19b. Maili                              | ng Address (Street a                         | nd Number or Run               | al Route Number, C                      | ity or Town, State, Z               | ip Code)  |
|                | and<br>ealth<br>m 27  |                      | Lorraine F. Watki   | ins (Wife)   | 20b. Place of Dispo                     | nda Lane                                     | Severna I                      | ark Mary                                | Land 21146<br>c. Location - City or | Tourn State                                     |
| Ore            | ges 1 and 2 should be filed within 72 hours after death with the Marylan It of Health and Mental Hygiene. If item 27 is marked other than "naturel", or Items 23a or 28a-f show or other traumatic event, the Water Examine must be notified at |                      | 20a. Method of Disposition 1 ☐ Surial 2 ☐ Cremation 3 ☐   | Removal from State   | cemetery, cre                           | matory or other place                        |                                |   |                                     |   |
| Saltimore,     | nit. Parantmen ortant: Injury   |                      | `4 □ Donation 5 □ Other (Specify  |  |   | en Mem. Pl                                   |                                | 23/05 G                                 | Len Burnie                          | e, Maryland                                     |
| Bal            | permit. Pages 1 and 2<br>Department of Health<br>Important: If item 27 i<br>any Injury or other tra<br>once.  |                      | 21. Signature of Funeral Service Licen.   | ///-   | M                                       | cCully-Po                                    | lyniak Fr                      | meral Hor                               | P.A.<br>Maryland                    |   |
| 100            | UES. D. 181   |                      | 23a. Part 1. For the disease, or comp   | plications that caused the   | he death. Do not en                     | 204 Mount:<br>ter the mode of dying          | ain Road<br>La such as cardiac | Pasadena.<br>or respiratory arrest      | _MaryLand                           | Approximate                                     |
|                |   |                      | shock, or heart failure. List only of<br>Immediate Cause (Final   | one cause on each line   |   | 14 1   | 1 1                            |   |                                     | Interval Between<br>Onset and Death             |
|                | Physician /Medical  |                      | disease or condition resulting in death)  | a Maliq  | consequence of):                        | Mesot  | 46/10x                         | na                                      |                                     | 10months  |
| *              | Examiner  |                      |   |  | consequence or).                        |  |                                |   |                                     |   |
|                | <u></u>   | Jer                  | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | Due to (or as a  | consequence of):                        |  |                                |   |                                     |   |
|                | outed<br>d<br>ansit   | Examiner             | Cause (Disease or injury that initiated events  | C  |   |  |                                |   |                                     |   |
| o,             | be executed<br>ician and<br>burial-transit  |                      | resulting in death) Last  | Due to (or as a  | consequence of):                        |  |                                |   |                                     |   |
| 8760           | e ys  | by Physician/Medical | (   | d  |   |  |                                |   |                                     |   |
| 9              | eath certificate<br>attending phys  | Med                  | IF FEMALE:  |  |   |  |                                |   |                                     |   |
| Box            |   | lan/                 | 23b. Was decedent pregnant in the past 12 months?   | 23c. If yes, outcome of  | Fetal death 3                           | □Ectopic pregnancy                           |                                |   | 23d. Date of deli<br>Month          | very<br>Day Year                                |
| 0              | 0 0   | ysic                 | 1 ☐ Yes 2 ☑ No<br>9 ☐ Unknown   | 4□Pregnant at ti<br>9□ Unknown   | me or death 5 (                         | Other (specify)                              |                                |   |                                     |   |
| م:             | that the od by detac  | P                    | Part II. Other significant conditions of  | ontributing to death but   | not resulting in the t                  | underlying cause give                        | n in Part I.                   | 23e. Did tobac                          | cco use contribute to               | the cause of death?                             |
| Vital Records, | requires that the<br>een signed by th<br>nould be detache   | d b                  |   |  |   |  |                                | 1 🗆 Yes                                 | 2 No 3 □ Pr                         | obably 4 Unknown                                |
| Sor            | ≥   | Completed            |   |  |   |  |                                | 24a. Was an                             | 24b. Were au                        | topsy findings available                        |
| Re             | The law<br>ate has b<br>page 2 st   | Ĕ                    |   |  |   |  |                                | autopsy<br>performe                     | d? prior to death?                  | topsy findings available completion of cause of |
| ā              | ician: Th<br>certificate<br>rector, pag   | Ö                    | 25. Was case referred to medical  |  |   |  | 26. Place of Deat              | 1 ☐ Yes 2 b<br>h (Check only one)       | No 1 ☐ Yes                          | 503 140   |
|                |   | ToB                  | examiner?<br>1 ☐ Yes 2 ØNo  | Hospital:  | t 2 ☐ ER/Outpatie                       | nt 3 DOA Othe                                | NE                             |   | ce 6 Other (Spec                    | cify)   |
| o              |   |                      | 27. Manner of Death   | 28a. Date of Injury<br>(Month, Day   |   |  | at                             | 28d. Describe how                       |                                     |   |
| Ö              |   | atio                 | Natural 5 ☐ Pending 2 ☐ Accident investigation  | 1  | , |  | res 2 □No                      |   |                                     |   |
| Division of    | or Attendate deatl  | Certification:       | 3 Suicide 6 Could not be determined   | 28e. Place of Injur<br>building, etc.  | y - At home, farm, si<br>(Specify)      | reet, factory, office                        |                                | 28f. Location (Stree<br>City or Town, S | et and Number or Ru<br>State)       | ral Route Number,                               |
|                | ital or<br>irs afte<br>ral Dir<br>led in  |                      |   | 1  |   |  | ,                              |   |                                     |   |
|                | To the Hospital or Al within 24 hours after of To the Funeral Direction plately filled in by  | edical               |   | ysicien: To the best of  | examination and/or in                   |  |                                |   |                                     |   |
|                | To the within 2 To the comple   | Med                  | 29b. Signature and title of certifier.  | and manner state   | ed.                                     | 29c. License                                 | number                         | 29d                                     | . Date signed (Monti                | n, Day, Year)                                   |
|                | F ≥ F 8   |                      | 1.0ie 24  | Grahm  | entit                                   | DAS  | 15177                          | D                                       | eccube                              | 212005  |
| , 1            | 11/   |                      | 30. Name and address of person who  | completed cause of de  | ath (Item 23a) (Type                    | Print)                                       | 111/                           |   |                                     | •   |
| 1              | 0   |                      | Julie R. Brah   | mer, M.D   | ,1650                                   | Orleans                                      | Street:                        | Baltimor                                | e Haryla                            | (212005<br>(1231)                               |
|                | St  | ate                  | 31. Date filed (Menth, Pay Year)  | 75 Registra  | r's Signature                           | ack !  |                                |   |                                     | -   |
|                | Regist  | rar                  | 2000 120  | The same of the sa | 1 10 187                                |  |                                |   |                                     |   |

Certificate of Death

Reg. No.

State

Registrar

31. Date filed (Month, Day, Year)

2005

|    |  |                   | 1 - For<br>State<br>Registrar   | State of M   | laryland / De                          | epartme<br>Certifica |                          |                                       | Mental Hy                              | giene                          | 5 4                      | 1754                            |
|----|--|-------------------|---|--|--|----------------------|--------------------------|---------------------------------------|--|--------------------------------|--------------------------|---------------------------------|
|    |  |                   | 1. Decedent's Name (First, Middle, Last,  | )  |  |                      | _                        |                                       | 2. Date of De                          |                                | Year                     | 3. Time of Death                |
|    | Physici<br>/Medi   |                   | Alfred Edward V   | Varren   |  |                      |                          |                                       | Dec                                    | 16 20                          | 05                       | 7:35p M                         |
| •  | Examir   |                   | 4a. Facility Name (If not institution, give   | -  |  | 4b. City             | , Town, o                | r Location of Dea                     | ath                                    | 4c. County                     | of Death                 | 4                               |
|    | A TRANSPORT  |                   | belfir Health +   | Kehabi   |  | IR be                | 1 41                     | Lift lodge 24 Hr                      | 2 2 2(2:                               | Har                            | tor                      | d                               |
|    | Funeral  |                   | 5. Social Security Number 6. Sec. 12  | M 2□F 7. A   | ge (In yrs. last birtho<br>72          | Months               | er 1 Year<br>Days        | If Under 24 Hr<br>Hours Mir           | n. (Month, Da                          | ay, Year)                      | Coun                     |                                 |
|    | Director   |                   | Usual Residence of Decedent   |  | 12                                     |                      |                          |                                       | Sept.                                  | 7, 1933                        | Mar                      | yland                           |
|    | ylanc<br>how   |                   | 10a. State 10b. County  |  | 10c. City, Town o                      | r Location           |                          |                                       |  |                                | 10                       | Od. Inside City Limits          |
|    | e Wa   | ctor              | Maryland Harford  |  | Abingo                                 | lon                  |                          |                                       |  |                                |                          | 1 ☐ Yes ¾☐ No                   |
|    | or 28  | Director          | 10e. Street and Number  |  |  | 10f. Z               | ip Code                  |                                       |  | 10g. Citizen of V              | /hat Count               | try?                            |
|    | a 23e  |                   | 28 Huxley Circle  | 10.111   |  | 10.111               | 210                      |                                       | 10 4 W                                 | USA                            |                          |                                 |
|    | b<br>after death with the Marylan<br>or itema 23s or 28s-1 show<br>oriner must be notified at  | Funeral           | 11. Marital Status 1 ☐ Never Married 2 ☑ Married  | <ol> <li>Was Decedent<br/>Armed Forces</li> <li>1 X Yes 2 □</li> </ol> | ?<br>No                                | If Yes, sp           | edent of H<br>ecify Cuba | ispanic Origin? (<br>an, Mexican, Pue | Specify Yes or No<br>erto Rican, etc.) | Blac                           | - America<br>k, White, e |                                 |
| Š  | J.S. aff   | by                | 3 Widowed 4 Divorced  | If Yes, Give<br>Year or Dates:   |  | 1 🗆 Yes              | 2 <b>⊠</b> No            | Specify:                              |  | Specify                        | wh                       | ite                             |
| Š  | d 21215-UU36<br>filed within 72 hours after death with the Maryland<br>Hygiene.<br>uther than "natural", or items 23a or 28s-1 show<br>ont, tre Medical Examination notified at  | ted               | 15. Decedent's Edu  |  | 16a. D                                 | ecedent's Us         | ual Occup                | ation<br>during most of w             | odvina                                 | 16b. Kind of Bu                |                          |                                 |
| Ž  | ZTZTS<br>3 within 7.<br>giene.<br>r than "n  | Completed         | (Specify only highest grad  | College (1-4or   | 11                                     | fe. DO NOT           | use retired              | d)                                    | Orking                                 |                                |                          |                                 |
| Š  | ygien<br>ygien<br>t. Et  | ပို               |   | 4  | En                                     | gineer               | -                        |                                       |  | Aerospac                       |                          | chnology                        |
|    | D be fill H be of other bear of the state of | Be                | 17. Father's Name (First, Middle, Last)   |  |  |                      |                          |                                       | ame (First, Middle                     |                                | θ)                       |                                 |
|    | Maryland 21215-0036 td 2 should be filed within 72 hours aft th and Mantal Hyglene. 27 is marked other than "natural", or traumatic event, tra Madical Exerti- traumatic event, tra Madical Exerti-  | 2                 | Leon Carl Wari  |  | 19b A                                  | Aailing Addres       | ss (Street               |                                       | (unk) Sr<br>Rural Route Numb           | oroll                          | State Zin                | Code                            |
|    | , Maryland 2 and 2 should be filed w salth and Mental Hygie n 27 is marked other t ser traumatic event, to   |                   | Margarte A. Warrer  |  |  |                      |                          |                                       | ingdon. M                              |                                |                          | ·                               |
|    | Ore, M<br>ges 1 and 2<br>t of Health<br>if Item 27 i   |                   | 20a. Method of Disposition  |  | 20b. Place of D                        |                      |                          |                                       | Date                                   | 20c. Location -                |                          |                                 |
|    | Pages Pages of Pint: If ite  |                   | 1X Burial 2 ☐ Cremation 3 ☐ F<br>4 ☐ Donation 5 ☐ Other (Specify)   |  | Parkwoo                                |                      |                          | !                                     | -20-05                                 | Baltimor                       | - M                      | bac lane                        |
| 3  | Baltimore, permit. Pages 1 ar Department of Hea important: if item any injury or othe  |                   | 21. Signatury of Fun All Service Qoylis   | ee /   | FBIKWO                                 | 22 Name              | and Ad                   |                                       | Home, P.A                              | raremen                        | C, P                     | aryrand                         |
|    | <b>n</b> && = & &  |                   | Mrses 11 m  | MA   |  | 1317                 | Coke                     | sbury Ro                              | oad. Abir                              | nadon. Ma                      | rvla                     | nd 21009                        |
|    |  |                   | 23a. Part1. Enter the disease, or compleshock, or heart failure. List only of                               | ations that cause<br>ne cause on each I                                | d the death. Do not line.              | enter the mo         | de of dyin               | ng, such as cardi                     | ac or respiratory a                    | rrest,                         | _                        | Approximate<br>Interval Between |
|    | Physician  | ı                 | Immediate Cause (Final disease or condition   | 17   | cute                                   | le                   | uk                       | emio                                  | 1                                      |                                |                          | Onset and Death                 |
|    | /Medical<br>Examiner   |                   | resulting in death)   | Due to (or as  | s a consequence of)                    | :                    |                          |                                       |  |                                |                          |                                 |
|    |  | _                 | Sequentially list conditions,   | One to for as  | s a consequence of                     |                      |                          |                                       |  |                                |                          |                                 |
| 80 | ited<br>Insit  | Examiner          | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | 300 10 (0. 00  | , a consequence on                     | •                    |                          |                                       |  |                                |                          |                                 |
| `  | /6U, le be executed ysician and e burial-transit   | Exa               | that initiated events<br>resulting in death) Last   | Due to (or as  | a consequence of)                      | :                    |                          |                                       |  |                                |                          |                                 |
| Š  | Hecords, P.O. Box 68/60,  The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transitions.  |                   |   | d  |  |                      |                          |                                       |  |                                |                          |                                 |
| (  | OX 68<br>ortifica<br>ording ph<br>use as th  | Physician/Medical | IF FEMALE:  |  |  |                      |                          |                                       |  |                                | - 1/                     |                                 |
|    | BOX<br>eath cert<br>attendin<br>for use  | an/               | 23b. Was decedent pregnant in the past 12 months?   | 3c. If yes, outcome<br>1 ☐ Live birth                                  | e of pregnancy<br>2  Fetal death       | 3 □Ectopic           | pregnancy                | ,                                     |  | 23d. Date<br>Mor               | of deliver               | y<br>Day Year                   |
|    | at the dea<br>by the a   | sici              | 1 Ves 2 No  | 4□Pregnant a<br>9□Unknown  | at time of death                       | 5 Other (            | specify)                 |                                       |  | NAIOI                          |                          | Jay 16ai                        |
|    | that the ded by the detached   |                   | Part II. Other significant conditions con   | ntributing to death l  | but not resulting in th                | ne underlying        | cause div                | en in Part I                          | 23e. Did 1                             | tobacco use contr              | bute to the              | e cause of death?               |
| 5  | ecords, law requires t as been signe   | d by              |   | 3  | •                                      | ,,                   | J                        |                                       | 1 🗆                                    |                                |                          | ibly 4 □Unknown                 |
| 2  | COTG w requir been si  | Completed         |   |  |  |                      |                          |                                       | 24a. Was                               | an 24h V                       | /ere auton               | sy findings available           |
| 7  | The lar  | E G               |   |  |  |                      |                          |                                       | auto<br>perfe                          | psy p<br>ormed? d              | rior to comeath?         | pletion of cause of             |
| 2  |  | Be C              | 25. Was case referred to medical  |  |  |                      |                          | 26. Place of De                       | 1 ☐ Yes<br>eath Check only             |                                | ☐ Yes :                  | 2□ No                           |
| ~  | OT VITA Physician: this certific al director,  | To B              | examiner? 1 \( \text{Yes} \) 2 \( \text{No} \)  | lospital:<br>1 ☐ Inpati  | ient 2 ER/Outpa                        | atient 3 🗆 🗆         | Dth                      |                                       | Home 5□Resi                            |                                | r (Specify               | )                               |
|    | On Ol<br>ding Ph<br>h.<br>After th<br>tuneral  |                   | 27. Manner of Death 1 Natural 5 □ Pending   | 28a. Date of Inju  | ury 28b. Tim<br>ay Year) Inju          |                      | 28c. Injun<br>Wor        |                                       |  | how injury occurre             |                          |                                 |
| 0  | ISIO<br>Mtendi<br>death.<br>ctor: A<br>y the fu  | cati              | 2 Accident investigation 3 Suicide 6 Could not be   |  |  | М                    |                          | Yes 2 □ No                            |  | _                              |                          |                                 |
| 17 | DIVISION  I or Attending after death. Director: After Jin by the fune  | Certification:    | 4 Homicide determined   | 28e. Place of In<br>building, e  | ijury - At home, farm<br>tc. (Specify) | , street, facto      | ry, office               |                                       | 28f. Location (<br>City or To          | Street and Numbe<br>wn, State) | er or Aural              | Route Number,                   |
| -  | urs<br>urs<br>srai   | 20                | 29a. Certifying Phy   | sician: To the best  | of my knowledge of                     | leath occurre        | d at the tin             | me date and play                      | and due to the                         | cauco(s) and ma                | anor ac et               | tod.                            |
| A  | To the Hospital within 24 hours a To the Funeral completely filled   | edical            | (Check only 2 Medical Exemi   | ner: On the basis of<br>and manner st                                  | of examination and/o                   | or investigation     | n, in my o               | pinion, death occ                     | curred at the time,                    | date and place, a              | nd due to                | the cause(s)                    |
| _  | To th<br>within<br>To th   | ₩                 | 29b. Signature and title of certifier   |  |  |                      | 9c. Licens               |                                       |  | 29d. Date signed               | (Month, E                | Day, Year)                      |
|    |  |                   | > Stroze  | _  |  |                      | DZE                      | 5545                                  |  | 12/2                           | 1/05                     |                                 |
| •  | 8+1  |                   | 30. Name and address of person who con SHILPI KHOSGA  | ompleted cause of 206 }  | death (Item 23a) (Ty                   | rpe, Print)          | 2,6                      | BEL AIN                               | Z, MD                                  | 21014                          |                          |                                 |
|    | Sta<br>Regist  | ate<br>rar        | 31. Date filed (Month, Day, Year) DEC 2 7 2005  | 32. Regist   | rar's Signature                        | SE O                 |                          |                                       |  |                                |                          |                                 |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** December 19, 2005 9:40 AM M Nathan Waterbury /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore 1736 S. Hanover Street If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 6. Sex 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Hours 1 M 2 F Director 49 29,1956 MARYLAND 216 68 3329 Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28e-f show r than "natural", or Items 23a or 28e-f show the Wedical Examinar must be notified at BALTIMORE 1 Yes 2 No Director MD. N/A 1736 S. HANOVER ST. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1736 S. HANOVER ST. 21230 USA Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: SpecifyWHITE Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7. Department of Health and Mental Hygiene Important: if Item 27 is marked other than "ne any Injury or other traumatic event, the Media 9:10. Elementary/Secondary (0-12) College (1-4or 5+) AUTO DETAILER TOYOTA 17. Father's Name (First, Middle, Last) Be HAROLD A WATERBURY THELMA B. TURNER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (wife) 6961 Brookmill Pd BALTO MD. 21215
20b. Place of Disposition (Name of Date Date 20c. Location - City or Town, State LINDA LEBON WATERBURY 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State GREEN MOUNT CREMATORY DEC. 23,2005 BALTO, MD. \*4 □ Donation 5 □ Other (Specify) Signature of Funeral Service Licensee CALVIN B. SCRUGGS FUNERAL HOME 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximately a such as cardiac or respiratory arrest, shock or heart failure. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) METASTATIC SQUAMOUS CANCER OROPHARYNX Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner The law requires that the death certificate be executed use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Year Pregnant at time of death 5 Other (specify) □Yes 2□No 9☐ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death? has 1 ☐ Yes 2 ☐ No 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one, Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Natural
2 Accident 5 Pending 1 □ Yes 2 □ No investigation Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 \( \text{Homicide} To the Hospital or within 24 hours af To the Funeral D Tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature applitte of certifies DECEMBER 23, 2005 D16354 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 900 CATON AVE BALTIMORE MD 21229 ST AGNES E.W. COLE MD 31. Date filed (Month, Day, Year) Registrar's Signature State DEC 2 7 2005 Registrar

| DΑ                             | WARCZY   | ZNS               | KI<br>1 - State<br>Registrar   | State of Ma   | aryland / Dep<br><i>Ce</i>              | artment of F                               |   |  | iene<br>g. No. 005                              | 41756   |
|--------------------------------|--|-------------------|--|---|---|--|---|--|---|---|
|                                |  |                   | Decedent's Name (First, Middle, Last,  | )   |   | ,  |   | 2. Date of Deat                            |   | 3. Time of Death                                |
|                                | Physici  |                   | LINDA MARI   | E WARC  | ZYNSKI                                  |  |   | DEC.                                       | 2005° 2005°                                     | 5:15 Рм   |
|                                | /Medic<br>Examin   |                   | 4a. Facility Name (If not institution, give 1801 FLEET STREE)  |   |   |  | or Location of Death                            |  | 4c. County of Deat                              | h   |
|                                | Funeral<br>Director  |                   | 5. Social Security Number 6. Sec<br>218-50-7133  | x 7. Ag   | 6 (In yrs. last birthday)<br>55 Yrs.    | If Under 1 Year<br>Months Days             | If Under 24 Hrs.<br>Hours Min.                  | 8. Date of Birth<br>(Month, Day,<br>FEB. 1 | Year) 9. Birtl                                  | npiace (State or Foreign<br>untry)<br>ARYLAND   |
|                                | pu k   |                   | Usual Residence of Decedent  10a. State 10b. County  |   | 10c. City, Town or L                    | ocation                                    |   |  |   | 10d. Inside City Limits                         |
|                                | Maryla<br>f eho  | ٥                 | MD. N/A  |   | BALTI                                   |  |   |  |   | 1 X Yes 2 □ No                                  |
|                                | 28a-   | Director          | 10e. Street and Number   |   | DALII                                   | 10f. Zip Code                              |   | 1  | 0g. Citizen of What Co                          | untry?  |
|                                | h with   | a D               | 1801 FLEET STR   | EET   |   | 21   | 231   |  | U.S.A.  |   |
| 98                             | permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If tiem 27 is marked other then "natural", or items 23s or 28s-f ehow any injury or other traumatic event, it is Medical Examinar must be notified at once. | y Funerai         | 11. Marital Status 1 ☑Never Married 2 ☐ Married  | 12. Was Decedent Armed Forces? 1 ☐ Yes 2 🕅 North House (1988)       | Ever in U.S. 13.                        |  | Hispanic Origin? (Spe<br>an, Mexican, Puerto F  | cify Yes or No-<br>Rican, etc.)            | 14. Race - Ame<br>Black, White                  | nican Indian,<br>a, etc.                        |
| Ş                              | hours<br>lural',   | d by              | 3 Widowed 4 Divorced   | Year or Dates:  | l top Door                              | edent's Usual Occur                        |   |  | Specify: WH                                     |   |
| Baltimore, Maryland 21215-0036 | within 72<br>ene.<br>then na'  | Completed         | 15. Decedent's Edu<br>(Specify only highest grad<br>Elementary/Secondary (0-12)<br>1 2                         |   | (Give                                   | s kind of work done DO NOT use retire      | during most of working<br>d)                    | g  | LAW FIRM  | ind <i>us</i> try                               |
| 0                              | i Hygie<br>other   | Be C              | 17. Father's Name (First, Middle, Last)  |   |   |  | 18. Mother's Name                               |  |   |   |
| <u>lar</u>                     | uld be<br>Mentai<br>irked c  | ToB               | EUGENE A. WA   | RCZYNSKI  |   |  | MARIE   | R. R                                       | OMANUK  |   |
| ary                            | 2 should<br>and Men<br>is marks<br>sumatic   | z Y               | 19a. Informant's Name/Relationship (Ty   |   |   | 100  |   |  | . City or Town, State, 2                        |   |
| <u>^</u>                       | and<br>lealth<br>m 27  |                   | EUGENE WARCZYNS  | KI/FATHI  | -                                       |  | THE PARTY NAMED IN COLUMN TWO IS NOT THE OWNER. |  | RE, MARYLA                                      |   |
| imor                           | Pages 1<br>ment of H<br>ant: If ite<br>ury or of   |                   | 20a. Method of Disposition  1   ↑ Burial 2 □ Cremation 3 □ F  4 □ Donation 5 □ Other (Specify)                 |   | ST. STA                                 | matory or other pla<br>NISLAUS             | CEM. 12   | /23/05                                     | 20c. Location - City or BALTIMOF                | RE, MARYLAN                                     |
| Ball                           | permit. Departm<br>Departm<br>Importa<br>any inju  |                   | 21. Signature of Funeral Sauce Licens  | 99  | 1                                       | 2. Name and Addre                          | ZEILER I  | NC. FU                                     | NERAL HON<br>LTIMORE,                           | 1E  |
|                                | 40240  |                   | 23a. Part1. Enter the disease, or compl  | ications that caused  | the death. Do not en                    | 901 EAS                                    | TERN AVE  | NUE, BA                                    | LTIMORE, N                                      | 1D. 21231<br>Approximate                        |
| 1                              | hysician<br>/Medical   | 9 3               | shock, or heart lailure. List only or<br>Immediate Cause (Final<br>disease or condition<br>resulting in death) | ne cause on each lir<br>a Atheroc                                   | a consequence of):                      |  |   |  | 59  | Interval Between<br>Onset and Death             |
|                                | Examiner   | iner              | S. uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury     | b. Due to (or as  | a consequence of):                      |  |   |  |   |   |
| 8760,                          | icate be executed<br>physicien and<br>s the burial-trensit   | icai Examiner     |  | Due to (or as   | a consequence of):                      |  |   |  |   |   |
| .O. Box 68                     | The law requires that the death certificate be executed tile has been signed by the attending physicien and bage 2 should be detached for use as the burial-trensit  | Physician/Medical | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 10 Unknown                       | 23c. If yes, outcome<br>1☐Live birth<br>4☐Pregnant at<br>9☐ Unknown | 2 Fetal death 3                         | □Ectopic pregnanc<br>□ Other (specify) _   | y   |  | 23d. Date of deli<br>Month                      | very<br>Day Year                                |
| rds, P                         | quires that<br>n signed b<br>uld be deta   | þ                 | Part II. Other significant conditions con  | ntributing to death b   | ut not resulting in the t               | underlying cause giv                       | ven in Part I.                                  |  | pacco use contribute to                         | 1.4.  |
|                                |  | Completed         |  |   |   |  |   | 24a. Was ar<br>autops<br>perform           | y prior to d                                    | topsy lindings available completion of cause of |
| <u>. ta</u>                    | ysician: The   | Bec               | 25. Was case referred to medical examiner?   |   |   |  | 26. Place of Death                              |  |   |   |
| 2                              | Physic<br>this ce<br>al dire   | ၉                 | 1X Yes 2 □ No  | lospital: 1   Inpatie   |   | THE SEL DON                                |   |  | ence 6 Other (Spec                              | AT SCENE  |
| sion                           | Attending Physician: r death. ector: After this certification the funeral director.  | ation;            | 27. Manner ol Death  1 Natural 5 Pending 2 Accident investigation  | 28a. Date of Inju<br>(Month, Day                                    | y Year) 28b. Time o                     | Wo   | y at<br>rk?<br>Yes 2 □ No                       | 8d. Describe ho                            | w injury occurred                               |   |
| DIVI                           | 5 # 5 E  | Certification;    | 3 Suicide 6 Could not be 4 Homicide determined   | 28e. Place of Inju-<br>building, etc                                | ury - At home, larm, st<br>c. (Specify) | reet, lactory, office                      | 2   | 81. Location (St.<br>City or Town          | reet and Number or Ru<br>, State)               | ral Route Number,                               |
|                                | To the Hospital within 24 hours a To the Funeral completely filled   | edical            | 29a. Certifier (Check only one) 1 Certifying Phy   | sician: To the best oner: On the basis of and manner sta            | examination and/or in                   | th occurred at the tinvestigation, in my o | me, date and place, a ppinion, death occurre    | nd due to the ca<br>d at the time, da      | ause(s) and manner as<br>ate and place, and due | stated.<br>to the cause(s)                      |
|                                | with<br>Com  | Σ                 | 29b. Signature and title of certifier  | mi  |   | 29c. Licens<br>().(                        | c.M.E   | 29   | DEC. 21, 2                                      | , Day Year)<br>COO5                             |

State Registrar

32. Pagistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

LING LE M. THE PENN STREET, BALTIMORE, MARYLAND 21201

|                   |  |                   | 1 - For<br>Stata<br>Registrar   |  | of Maryla  |                                    | artmen<br>rtificate       |                          |                             | and N                | fental Hy                       | giene 0                                 | 5             | 41757  |
|-------------------|--|-------------------|---|--|--|------------------------------------|---------------------------|--------------------------|-----------------------------|----------------------|---------------------------------|---|---------------|--|
| м                 | Physici  | ian               | Decedent's Name (First, Mide     MARGARET   |  | ILEY   |                                    |                           |                          |                             |                      | 2. Date of De<br>Month          | BER 23,                                 | Year          | 3. Time of Death                                   |
|                   | /Medi  |                   | 4a. Facility Name (If not instituti   |  |  |                                    | 4h City                   | Town or                  | Location o                  | of Death             | DECEMI                          | 4c. County of                           |               |  |
|                   | Examir   | ner               | JOSEPH RICH   |  |  |                                    |                           |                          | MORE                        |                      |                                 |   | N/A           |  |
| - 10              | Funeral  |                   | 5. Social Security Number   | 6. Sex   |  | s. last birthday)                  | If Under<br>Months        |                          | If Under 2                  |                      | 8. Date of Bir                  | rth                                     | 9. Birth      | place (State or Foreign                            |
|                   | Director   |                   | 218-01-6602   | 1□M 2 <b>X</b> F                                     | 84   | Yrs.                               | Months                    | Days                     | Hours                       | MHI.                 | JAN.                            | 30,1921                                 | MA            | RYLAND   |
|                   | land<br>W  |                   | Usual Residence of Decedent  10a. State 10b. Count  | ly   | 10c. C   | ity, Town or Lo                    | cation                    |                          |                             |                      |                                 |   |               | 10d. Inside City Limits                            |
|                   | Mary<br>I-f sh   | to                | MD.   | N/A  |  | BAL                                | TIMOR                     | RE                       |                             |                      |                                 |   |               | XXYes 2□No   |
|                   | th the   | Director          | 10e. Street and Number  |  |  |                                    | 10f. Zip                  |                          |                             |                      |                                 | 10g. Citizen of W                       | hat Cou       | intry?   |
|                   | ath wi   | rai               | 3904 FOSTER   |  |  |                                    |                           | 212                      | 24                          |                      |                                 | U.S.                                    | Α.            |  |
|                   | ltems<br>ltems   | Funeral           | 11. Marital Status  | Armed F  |  | U.S. 13.                           | Was Deced<br>If Yes, spec | ent of His               | spanic Orig<br>n, Mexican   | gin? (Sp<br>, Puerto | ecify Yes or No<br>Rican, etc.) | o- 14. Race<br>Black                    | - Ameri       | ican Indian,<br>, etc.                             |
| 36                | rs aft   | by F              | 1X Never Married 2 Ma<br>3 Widowed 4 Divorce  | If Yes G   | 2 <b>X</b> ONNo<br>live<br>Dates:                    |                                    | 1 ☐ Yes 2                 | 2X No                    | Specify:                    |                      |                                 | Specify:                                | TA7111 ·      | ITE  |
| 21215-0036        | 72 hours after deeth with the Maryland<br>Insture!, or Items 23s or 28s-f show<br>dical Examiner must be notified at   |                   | 15. Decede  | ent's Education                                      |  | 16a. Dece                          | dent's Usua               | I Occupa                 | ition                       |                      |                                 | 16b. Kind of Bus                        |               |  |
| 218               | within 7<br>ene.<br>than "r  | Completed         | (Specify only night<br>Elementary/Secondary (0-12)  | est grade completed<br>College                       | (1-4or 5+)   |                                    | kind of wor<br>DO NOT us  |                          |                             | ot work              | ing                             |   |               |  |
| 21                | filed with<br>Hygiene.<br>other than   | Sol               | 8   |  |  | MA                                 | ACHIN                     | IST                      |                             |                      |                                 |   |               | ELECTRIC   |
| Maryland          | ould be fi<br>Mental H<br>arked otl<br>atic ever   | Be                | 17. Father's Name (First, Middle  |  |  |                                    |                           |                          |                             |                      |                                 | , Maiden Sumame                         | )             |  |
| Z                 | and Men<br>is marke  | 스                 | HOWARD WIT  | LEY  |  | 19b Mailin                         | na Address                | (Street a                |                             |                      | NDA ZO                          | ORN<br>er, City or Town, S              | tato Zi       | a Code)  |
|                   | s 1 and 2 should be filed within 72 hours after deeth with the Marylan f Health and Mental Hyglene. Item 27 is marked other than "neturel", or items 23e or 28e-f show other treumatic event, the Macical Expirition interpretable to nullified at |                   | MARGARET MAI  |  | K/NIEC   |                                    |                           |                          |                             |                      |                                 |   |               | 21224  |
| Saltimore,        | of Hez   |                   | 20a. Method of Disposition  |  | 20b.   | Place of Dispo                     | sition (Nam               | e of                     | - !                         |                      | Date                            | 20c. Location - C                       |               |  |
| Ē                 | Pag<br>ment<br>ant: h  |                   | 1 ☐XBurial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (   |  | 1 State  | -                                  | •                         |                          | ·                           | US                   | 12/28/                          | 05 BALT                                 | 'IMC          | ORE.MD.  |
| 3alt              | permit. Pag<br>Department<br>Important:<br>eny injury c  |                   | 21. Signature of Funeral Servi-   | ticensee   |  | 22                                 | Name and                  | d Address                | s of Facility               | V                    |                                 | Addition to                             | -             | 2012 ATT   |
| 4                 | 40 E 5 8   |                   | - Carlo   |  | Tolo   |                                    | /00 S                     | . C                      | ÖNKĽ                        | ĬÑG                  | 'SI:, É                         | SALTO., M                               | ID.           |  |
|                   |  |                   | 23a. Part1. Enter the disease, of shock, or heart failure. Lis  | or complications that<br>it only one cause on        | each line.   | ith. Do not ent                    | er the mode               | of dying                 | , such as                   | cardiac (            | or respiratory a                | rrest,                                  |               | Approximate<br>Interval Between<br>Onsetiand Death |
| ji.               | Physician<br>/Medical  |                   | Immediate Cause (Final disease or condition resulting in death)   | a  | HSP  | HVSIA                              |                           |                          |                             |                      |                                 |   | )             | Montes   |
|                   | Examiner   |                   |   | Due to   | (or as a conse                                       |                                    | 2010 Z                    | ina mi                   | 100                         | ( (                  | Long                            | Chan                                    |               | 7mx  |
|                   |  | Jer               | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | b. Due to  | (or as a conse                                       |                                    | OCIV S                    | MALL                     | 100                         | Ч                    | COIL                            | CAIKEN                                  | Eur           | 7710   |
|                   | cuted<br>nd<br>ransit  | Examiner          | that initiated events   | <b>S</b> c   |  |                                    |                           |                          |                             |                      |                                 |   |               |  |
| 90                | cate be executed<br>bhysician and<br>the burial-transit  |                   | resulting in death) Last  | Due to   | (or as a conse                                       | quence of):                        |                           |                          |                             |                      |                                 |   |               |  |
| 8760,             | cate b<br>physic<br>the b  | dica              |   | d  |  |                                    |                           |                          |                             |                      |                                 |   |               | 4 16-1-  |
| 9 x               | The law requires that the death certificate be executed the has been signed by the attending physician and age 2 should be detached for use as the burial-transit  | Physician/Medical | IF FEMALE:  | 23c. If yes, or                                      | utcome of pregn                                      | iancy                              |                           |                          |                             |                      |                                 | 22d Date                                | of delice     |  |
| Вох               | death<br>a atter<br>d for u  | ciar              | 23b. Was decedent pregnant<br>in the past 12 months?<br>1 ☐ Yes 2 ☐ No                                      | 1 Live   | birth 2 Fet  | al death 3□                        | Ectopic pre<br>Other (spe |                          |                             |                      |                                 | 23d. Date<br>Mont                       |               | Day Year   |
| P.0               | at the de<br>by the a<br>tached  | hys               | 9 Unknown   | 9□ Unkr  | nown   |                                    |                           |                          |                             | -                    |                                 | -                                       |               |  |
| S,                | es thai<br>igned b   | ру Р              | Part II. Other significant condit   | ions contributing to d                               | death but not re                                     | sulting in the ur                  | nderlying ca              | iuse givei               | n in Part I.                |                      | 23e. Did t                      | obacco use contrib                      | ute to t      | he cause of death?                                 |
| ord               | w requir<br>been si<br>should  | ted               |   |  |  | <del> </del>                       |                           |                          |                             |                      | 1 🔯                             | Yes 2 □ No 3                            | Prot          | oably 4 Unknown                                    |
| of Vital Records, | e faw<br>has b   | Completed         |   |  |  |                                    |                           |                          |                             |                      | 24a. Was<br>autop               | osv ori                                 | or to co      | opsy findings available impletion of cause of      |
| al F              |  |                   |   |  |  |                                    |                           |                          |                             |                      | perto                           |   | ath?<br>] Yes | 2 🗆 No   |
| Z.                | Physician:<br>this certific<br>al director,  | o Be              | 25. Was case referred to medical examiner?  1 Yes 2 No  | Hospital:  |  | 2500                               |                           | Other                    | -                           | 1 -                  | Check only o                    | V1050.                                  | 1E            | - 1500 - 10 - 10 - 10 - 10 - 10 - 10 - 1           |
|                   |  | <b>-</b>          | 27. Manner of Death   |  | Inpatient 2 of Injury<br>of Day Year)                | ER/Outpatien<br>28b. Time of       |                           | Sc. Injury<br>Work       | 4 🗀 Nur                     |                      |                                 | dence 6 Other<br>now injury occurred    |               | (y)  |
| ion               | Attending I<br>r death.<br>ector: After<br>by the funer  | atio              | 1 Naturat 5 ☐ Pendi<br>2 ☐ Accident invest  | ing (Mor<br>tigation                                 | nth, Day Year)                                       | Injury                             | М                         |                          | ?<br>es 2 □ N               |                      |                                 | . ,                                     |               |  |
|                   | I or Atten<br>after deat<br>Director:<br>I in by the   | Certification:    | 3 ☐ Suicide 6 ☐ Could<br>4 ☐ Homicide deten   | mined 286. Place                                     | e of Injury - At h                                   | nome, farm, stre                   | eet, factory,             | office                   |                             |                      | 28f. Location (S<br>City or Tov | Street and Number                       | or Rura       | al Route Number,                                   |
| 9                 | itel or<br>ars afte<br>rel Dir<br>lled in  |                   |   |  |  |                                    |                           |                          |                             | -                    |                                 |   |               |  |
|                   | To the Hospitel or At within 24 hours after of To the Funerel Direct completely filled in by   | edical            | 29a. Certifier 1 Certifyi (Check only 2 Medica  | ing Physician: To the<br>I Examiner: On the band man | e best of my kno<br>pasis of examina<br>nner stated. | owledge, death<br>ation and/or in: | occurred a restigation, i | it the time<br>in my opi | e, date and<br>inion, death | l place, a           | and due to the e                | cause(s) and manr<br>date and place, an | ner as si     | tated.<br>the cause(s)                             |
|                   | To the within 2 To the complet   | Me                | 29b. Signature and title of certific  |  |  |                                    | 29c.                      | License                  | number                      |                      |                                 | 29d. Date signed (                      | Month,        | Day, Year)   |
|                   | 0  |                   | ▶ Wirtun  | A. Dei   | m M  | 0                                  | D                         | 100                      | 300                         | Ž                    |                                 | 1)0e. 2                                 | 4             | 101  |
| 8                 | 1  |                   | 30. Name and address of person  | who completed only                                   | se of death (Iter                                    | m 23a) (Type,                      | Print)                    |                          |                             |                      |                                 | 7                                       | 1             | 0  |
| U                 |  |                   | Dept (CI  | N3 17  | D5165  | = 8                                | 28 V                      | 1.51                     | DIAU                        | 7                    |                                 | JAYO                                    | M             | ) 9792   |
|                   | Sta<br>Registr   |                   | 31. Date filed (Month, Day, Year DEC 2  | 7 2005   | Registrar's Sign                                     |                                    | book                      | ,                        |                             |                      |                                 | J                                       |               |  |

|  |   |                     | 1 - For<br>Stete<br>Registrar   | State of M   |                                      | nd / Depa                                    |                          | t of H                   | ealth a                              |                        | lental Hy   |                                | -                                   | 417                                   | 58                    |
|--|---|---------------------|---|--|--------------------------------------|--|--------------------------|--------------------------|--------------------------------------|------------------------|---|--------------------------------|-------------------------------------|---------------------------------------|-----------------------|
| ı  | Physici   |                     | Decedent's Name (First, Middle, PHYLLIS   | Last)  |                                      | WEST   |                          |                          |                                      |                        | 2. Date of De<br>Month<br>December  | Day                            | Year                                | 3. Time<br>10:30                      | of Death $P_{M}$      |
|  | /Medic<br>Examin  |                     | 4a. Facility Name (If not institution, 7413 Crane Pl  |  | )                                    |  | 4b. City,                |                          | Location o                           |                        | Decembe   | 4c. (                          | , 2005<br>County of Dea<br>nce Ge   | ith -                                 |                       |
|  | Funeral<br>Director   |                     | 5. Social Security Number 578–58–6531  Usual Residence of Decedent  | 5. Sex 7. A<br>1 □ M 💥 ☐ F   | ge (In yrs.<br>61                    | last birthday)<br>Yrs.                       | If Under<br>Months       | 1 Year<br>Days           | If Under<br>Hours                    | 24 Hrs.<br>Min.        | 8. Date of Bir<br>(Month, Da<br>01/24/19  | th<br>ay, Ye <i>ar)</i><br>244 | 0                                   | thplace (State<br>ountry)<br>shingto  |                       |
|  | e-f show  | ctor                | 10a. State 10b. County  | George's   |                                      | y, Town or Lo<br>dover                       | cation                   |                          |                                      |                        |   |                                |                                     | 10d. Inside                           | City Limits           |
|  | 3a or 28  | Il Dire             | 10e. Street and Number<br>7413 Crane Place  | e  |                                      |  | 10f. Zip<br>207          | Code<br>785              | <u>-</u> . ·                         |                        |   |                                | en of What C<br>JSA                 | ountry?                               |                       |
| 980  | be filed within 72 hours after death with the Maryland<br>that Hygiene.<br>od other than "netural", or Items 23a or 28e-f show<br>avant. The Modical Exore activities Learing and | by Funeral Director | 11. Marital Status  1 Never Married 2 Marrie 3 Wildowed 4 Divorced  | 12. Was Deceden Armed Forces 1 Yes 2 1 1 Yes, Give Year or Dates:  | ?                                    |  | Vas Deced<br>f Yes, spec |                          | spanic Ori<br>n, Mexican<br>Specify: | gin? (Spe<br>i, Puerto | ecify Yes or No<br>Rican, etc.)   |                                | 4. Race - Am<br>Black, Whi<br>Black |                                       |                       |
| Maryland 21215-0036  | a filed within 72 ho<br>Il Hygiene.<br>other than "netur<br>vant, the wedical   | Completed           | 15. Decedent's<br>(Specify only highest<br>Elementary/Secondary (0-12)<br>12th  | Education<br>grade completed)<br>College (1-4or                    | 5+)                                  | 16a. Deced<br>(Give<br>life. L<br>Posta      | kind of wor<br>OO NOT us | rk done a<br>se retired, | ation<br>Juring most                 | t of worki             | ing   |                                | d of Business<br>ernment            | _                                     |                       |
| /land  | should be filed<br>and Mental Hygie<br>marked other<br>imatic avant, L  | To Be C             | 17. Father's Name (First, Middle, L. Phillip  | wood   |                                      |  |                          |                          |                                      |                        | (First, Middle  |                                | Sumame)<br>chell                    |                                       |                       |
| 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Co Charles West Jr., Son 7413 Crane Pl. Landover, MD. 20785 |   |                     |   |  |                                      |  |                          |                          |                                      |                        | Zip Code)   |                                |                                     |                                       |                       |
| Baltimore,   | permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic a gnce.  |                     | 20a. Method of Disposition  1 ☐ Burial 2 ☐ Cremation 3  4 ☐ Donation 5 ☐ Other (Spe   |  |                                      | Place of Dispo-<br>cemetery, cren<br>Itenham |                          |                          |                                      | 2/20                   | 2005  | رگاهد. لــــــ<br>Chelt        | ation . City or<br>enham,           | Town State                            |                       |
| Balt   | permit. Departr Importa any inji  |                     | 21. Signature of Funeral Service Li   | )  | ,                                    |  |                          |                          | s of Facilit                         |                        | St. NW,   | Washin                         | gtan, D                             | 20011                                 |                       |
| 3  | Physician   |                     | 23a. Part1. Boter the disease, or c<br>shock, or heart ail re. List of<br>Immediate Cause (Final<br>disease or condition          | omplications that cause<br>nly one cause on each                   | ine.                                 |  | er the mode              | e of dying               | , such as                            | cardiac o              | r respiratory a   | rrest,                         |                                     | Approxima<br>Interval Be<br>Onset and | etween                |
|  | /Medical<br>Examiner  |                     | resulting in death)   | Due to (or a   |                                      |  |                          |                          |                                      |                        |   |                                |                                     |                                       |                       |
| 8760,  | icate be executed physician and sthe burial-transit   | il Examiner         | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last | b. Due to (or as   |                                      |  |                          |                          |                                      |                        |   |                                |                                     |                                       |                       |
| .O. Box 687  | death certif<br>e attending<br>ed for use a   | Physician/Medical   | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown   | d.  23c. If yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown | 2 Feta                               | I death 3                                    | Ectopic pre              |                          |                                      |                        |   | 23                             | 3d. Date of de<br>Month             | ivery<br>Day                          | Year                  |
| <b>Q</b>   | law requires that the<br>as been signed by th<br>2 should be detache  | by                  | Part II. Other significant condition  | s contributing to death  | out not res                          | ulting in the ur                             | derlying ca              | ause give                | n in Part I.                         |                        |   |                                |                                     | the cause of obably 4 🖔               |                       |
| Vital Records,   | The<br>ate h<br>page  | Completed           |   |  |                                      |  |                          |                          |                                      |                        | 24a. Was<br>autor<br>perfo  |                                | 24b. Were as prior to death?        | utopsy findings<br>completion of      | available<br>cause of |
|  | Physician: Th<br>this certificate<br>ral director, pag  | To Be               | 25. Was case referred to medical examiner?  1 Yes 2 No  | Hospital:  | ent 2                                | ER/Outpatient                                | 3 DO                     | A Othe                   | _                                    |                        | Check on connection of the co |                                | ☐Other (Spe                         | cifv)                                 |                       |
| on of  | ding<br>h.<br>After<br>fune   |                     | 27. Manner of Death  1 Natural 5 Pending 2 Accident investiga   | 28a. Date of Inj<br>(Month, Da                                     | iry<br>ly Yea <i>r)</i>              | 28b. Time of<br>Injury                       | 28<br>M                  | Bc. Injury<br>Work<br>1  |                                      | 2                      | 28d. Describe   |                                |                                     | ,                                     |                       |
| Division   | i i i te  | Certification:      | 3 Suicide 6 Could no<br>4 Homicide determin   |  | jury - At ho<br>tc. <i>(Specif</i> ) | ome, farm, stre                              | eet, factory,            | , office                 |                                      | 2                      | 28f. Location (3<br>City or Tox   |                                | Number or Ri                        | ıral Route Nur                        | n <i>ber</i> ,        |
|  | To the Hospitel within 24 hours a To the Funeral t completely filled  | edical              | 29a. Certifier 1X Certifying (Check only one)   | Physicien: To the best<br>keminer: On the basis of<br>and manner s | of examina                           | wledge, death<br>tion and/or inv             | occurred a estigation,   | at the time<br>in my op  | e, date and<br>inion, deat           | d place, a             | and due to the<br>ed at the time,   | cause(s) a<br>date and p       | nd manner as<br>lace, and due       | stated.<br>to the cause(              | s)                    |
| •  | To T<br>To 1  | M                   | 29b. Signature and title of certifier   | telen.   | gru                                  | )  | 29c,<br>D 2              | 2374                     | number<br>3                          |                        | 1   | 29d. Date<br>2/19              | signed (Mont<br>7 2 0 0 5           | h, Day, Year)                         |                       |
|  | 8   |                     | 30. Name and address of person wind Martin weltz,   |  |                                      |  |                          | • ,                      | Gree                                 | nbe:                   | lt, MD  | . 2                            | 0770                                |                                       |                       |
|  | Sta<br>Registr  |                     | 31. Date filed (Month, Day, Year)  DEC 2 7 20   | 22. Regist   | rar's Signa                          |  |                          |                          |                                      |                        |   |                                |                                     |                                       |                       |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend item 5 per inf c852 2-22-06 vt.
State of Maryland / Gepartment of Health and Mental Hygiene

Amend Item 27 per Dr., G850, 12/2//05dhb

Certificate of Death

Reg/No. 0 5 1. Decedent's Name (First, Middle, Last) 2. Date of Death December 18, **Physician** 2005 11:25PM Evelyn Elizabeth Yeager /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4h. City. Town, or Location of Death Examiner Manor Care Roland Park N/A Baltimore 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Jan 5, 19 5. S**216-1248560** 6. Sex Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 1 M ADF 82 <del>852-39-1292</del> Yrs. Director Maryland Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10b. County 10d. Inside City Limits **ehow** 10a State 27 is marked other than "netural", or items 23a or 28a-1 ebov traumatic event, the McClical Examiner must be notified at 1 No 2 No Director N/A Baltimore Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3855 Greenspring Avenue 21211 USA Funera 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: White þ 3 ☐ Widowed 4 X Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 1 and 2 should be filed within Health and Mental Hygiene. Sm 27 Is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Clerk Bell Telephone 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be George Michael Freda Lynch 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Importent: If item 27 Is any Injury or other trau once. Daniel James Yeager, Son 3626 Malden Avenue Baltimore, Maryland 21211 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) 12/19/05 Baltimore, Maryland Metro Crematory Inc. <sup>22</sup> Name and Address of Facility
Cremation Society Of Maryland Inc.
299 Frederick Road Baltimore, Maryland 21228 21. Signature of Funeral Service Licensee
Thomas Gregor Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** perove disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Den Sequentially list conditions, if any, leading to immediate the sequence of the Due to (or as a consequence of): Examine use as the burial-transit brocare Chromen Due to (or as a consequence of): the attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ρ in the past 12 months?
1 Yes 2 No Month Day Year 4 Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an sorte certificate has Swamy 2 No Yes Hospital or Attending Physician: 25. Was case referre to med 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ 1√0 this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification; After 1 Natural Injury 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours after deat To the Funeral Director: 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of fnjury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D 31464 12/19/05 MD alba 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 &21 N. Enton St frite 300, BALTIMORE MD 21201 OM IMFIERTY 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend item#23a d, 25.27, 26a f, perff. (352, 2/13/06 IT State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2 Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year ZP.C **Physician** Ournara 24 2005 UKAUSKAS LZAH-/Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner 420H SPRIN If Under 24 Hrs. Jon Too Mily If Under 1 Year ROSS HOYS TAJ Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 6. Sex **Funeral** Days Min **™** M 2□ F Yrs AUG 10 PASSACHUSETT 0083 Director 212 62 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County item 27 is marked other than "natural", or itema 23a or 28a-1 ahow other traumatic avant, the Medical Examiner must be notified at 1 ☐ Yes 2 No MARCHAR PRINCE Director TLIDNEZZOC BURDE 10g. Citizen of What Country? 10f Zip Code 10e. Street and Number D.S. 6 20170-01729 48 G. ZJOY'S CAL Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 250 No 1 Never Married 28 Married 1 ☐ Yes 2 No Specify: Maryland 21215-0036 Specify: STIHW 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify onty highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 13402 PARE. SABBEC 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be is marked of JEANETTE YISACKI 2 JUKAUSKAS 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) ROAD GREEN BELT MARYLAND
Date | 20c. Location - City or Town, State 15,052 Health item 27 i 466. NZLL3 224 LUKAUSKAS Itimore, Or 39 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Department of H
important: if its
any injury or of
ance. Burial 2 Cremation 3 Removal from State 4 □ Donation 5 □ Other (Specify) 16RY/AMO BULAIR 1 EMORIAL 21. Signature of Funefal Service Licensee 22. Name and Address of Facility HAVEL—COLAIR
EVANT FUNCTORING FORTHILL GEDIE JARNANO 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) with complications ITHIUM TOXICITY WEEK **Physician** /Medical Due to (or as a consequence of): Examiner WEEKS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine inding physician and use as the burial-transit PPROVED BY MEDICAL EXAMINER ENCEPHLOPPIN MEEK J.XOM Due to (or as a consequence of) P.O. Box 68760, The law requires that the death certificate be WEEKL Physician/Medical TEWAL ALLOCE CERTIFICATIO attending p IF FEMALE: If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day 4☐Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Vital Records, Completed by Renal insufficiency, Hypertension, Diabetes, Morbid Obesity 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy 2X No certificate 1 ☐ Yes or Attanding Physician: 25. Was case referred to medical 26. Place of Death (Check only one) director Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes ZENO 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ٩ Division of this 28a. Date of Injury (Month, Day Year) 28b. Time of Injury unk 28c. Injury at Work? After thi 28d. Describe how injury occurred unk Certification: 27. Manner of Death 1 Natural 5 Pending 1 Yes 2 No within 24 hours after death.

To the Funeral Director: All completely filled in by the fu investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number of Bural Route Number, City or Town, State) 46 G Ridge Rd. 4 Homicide at home Greenbelt, MD Hospital TS Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b Signature and title of certified augz 5 AHMED NAWAZ PO Box 83819 mp Gailhersburg AHMED 32. Registrar's Signature 31. Date filed (Month, Day, Year) State DEC 2 Registrar 2005

DHMH 17 Rev 1/2001

ZUKADKAS

|                     |   |                  | For<br>State<br>Registrar   |                           | State of I                               |                | d / Depa   |                            | t of H             | ealth a       |                 |                                  |                   | 05                    | 417€  | 51                |
|---------------------|---|------------------|---|---------------------------|--|----------------|--|----------------------------|--------------------|---------------|-----------------|----------------------------------|-------------------|-----------------------|---|-------------------|
|                     |   |                  | 1. Decedent's Name (Fi  | irst, Middle, La          | st)                                      |                |  |                            |                    |               |                 | 2. Date of De                    | ath               |                       | 3. Time of I                                | Death             |
|                     | Physici<br>/Medio   |                  | Renato  | Z                         | ock                                      |                |  |                            |                    |               |                 | Dec.                             | 21 <sup>Day</sup> | 2005                  | 5:30  | $\mathbf{P}_M$    |
|                     | Examir  |                  | 4a. Facility Name (If not   | institution, giv          | e street and numb                        | er)            |  | 4b. City,                  | Town, or           | Location of   | of Death        |                                  | 4c. Cou           | nty of Deat           | h   |                   |
|                     |   |                  | 8361 Hild   | la Aveni                  | ıe                                       |                |  | F                          | asad               | dena          |                 |                                  | Ann               | e Aru                 | ındel                                       |                   |
|                     | Funeral   |                  | 5. Social Security Numb   |                           |  |                | last birthday)   | If Under<br>Months         | 1 Year<br>Days     | If Under:     | 24 Hrs.<br>Min. | 8. Date of Birt<br>June 8        | h<br>v. Year)     | 9. Birth              | hplace (State or                            | Foreign           |
| в                   | Director  |                  | 071-40-6146   | 0                         | [X]M 2□F                                 | 5              | 7 Yrs.   | IVIOINI IO                 | Days               | 710010        |                 | June 8                           | 1948              |                       | NY  |                   |
|                     | and *   |                  | Usual Residence of Dec<br>10a. State 10a  | b. County                 |  | 10c, Cit       | y, Town or Lo  | cation                     |                    |               |                 |                                  |                   |                       | 10d. Inside Cit                             | v Limits          |
|                     | laryli<br>sho   | ō                |   | Anne Ar                   | ımdel                                    |                | ,,   |                            | Pass               | adena         |                 |                                  |                   | i                     | 1 Tyes                                      |                   |
|                     | 28e-1   | ect              | 10e. Street and Number  |                           |  |                |  | 10f. Zip                   |                    |               |                 |                                  | 10g. Citizen      | of What Co            | <u> </u>                                    |                   |
|                     | with sa or  | Funeral Director |   |                           |  |                |  | 102.6                      | 211                | 100           |                 |                                  |                   |                       | and y                                       |                   |
|                     | ns 23   | era              | 8361 Hi   | tda Ave                   | 12. Was Decede                           | nt Ever in U.  | .S. 13. V  | Was Deced                  |                    |               | gin? (Spe       | ecify Yes or No-<br>Rican, etc.) |                   | USA<br>Race - Ame     | rican Indian,                               |                   |
| ယ                   | r ite   | 필                | 1 Never Married   | 2X Married                | Armed Force<br>1 X Yes 2<br>If Yes, Give |                |  |                            |                    |               | i, Puerto I     | Rican, etc.)                     | ì                 | Black, White          | _   |                   |
| ğ                   | el', o  | b                | 3 ☐ Widowed 4 ☐   | Divorced                  | If Yes, Give<br>Year or Date             | s:             |  | 1□Yes 2                    | 2XI No             | Specify:      |                 |                                  | Spe               | city: Wh              | iite  |                   |
| 5-0                 | d within 72 hours after death with the Maryland<br>Jiene.<br>Ir then "naturel", or items 23s or 28e-f show<br>The Madical Examiner must be natified at  | Completed        |   | Decedent's E              | ducation<br>ade completed)               |                | 16a. Deced   | dent's Usua<br>kind of wor | I Occupa           | ation         | t of workii     | na                               | 16b. Kind of      | Business/             | Industry                                    |                   |
| 2                   | within<br>ene.<br>then *  | nple             | Elementary/Secondar   |                           | College (1-4                             | or 5+)         | life. I  | DO NOT us                  | e retired          | )             |                 | ,9                               | ъ.                | • •                   |   |                   |
| 21                  | 77 75 10 10   | Cor              |   |                           |  |                | War  | ehous                      | emar               |               |                 |                                  | Reta              |                       |   |                   |
| pu                  | Q 50 0 0  | Be               | 17. Father's Name (Firs.  |                           |  |                |  |                            |                    |               |                 | (First, Middle,                  | Maiden Sum        |                       |   |                   |
| ₹<br>Z              | should be<br>nd Mental<br>marked o  | ပ                | Carlo   | R.                        | Zock                                     |                |  |                            |                    |               | onet            |                                  |                   |                       | .cca  |                   |
| Maryland 21215-0036 | s 1 and 2 should<br>f Health and Men<br>item 27 is marke<br>other treumetic   |                  | 19a. Informant's Name/  |                           |  | `              |  |                            |                    |               |                 | Route Numbe                      |                   |                       | Zip Code)                                   |                   |
| e,                  | s 1 and<br>if Healt<br>item 2:<br>other   |                  | Patricia 2  |                           | (Spouse                                  | ·              |  |                            |                    |               |                 | nma, Md                          | 20c. Locatio      |                       | Town State                                  |                   |
| Baltimore,          | Pages<br>nent of h<br>int: if ite   |                  | 1 □ Burial 2 💢 Cr   | remation 3                |  | ILO I          | Place of Dispo   |                            |                    | 1             |                 |                                  |                   |                       |   |                   |
| ţ                   | 그 문문를   | . 0              | `4 □Donation 5 □  |                           |  | Me             | etro Cr  | emato                      | ry l               | Inc.          | 12/22           | 2/05                             | Balti             |                       |   |                   |
| Bal                 | Depariment of the pariment of |                  | 21. Signature of Fune   | Service Lice              | 99                                       |                | 22   | . Name an                  | d Addres           | s of Facilit  | y Sta           | allings                          | Funer             | al Ho                 | me PA                                       |                   |
|                     | 407.60  |                  | 200 804 5000  | X 2)                      |  |                |  |                            |                    |               |                 | Pasaden                          |                   | 21122                 |   |                   |
|                     |   |                  | 23a. Parl1. Enter the dishock, or heart fa  |                           | one dayse on eac                         | h line.        | n. Do not ent  | er the mode                | e or ayını         | g, such as    | cardiac o       | r respiratory ar                 | rest,             |                       | Approximate<br>Interval Betw<br>Onset and D | reen              |
|                     | Physician   |                  | Immediate Cause (Fina<br>disease or condition<br>resulting in death)              | 1,                        | a  | Lend           | on h   | 1-el                       | Co                 | en a          |                 |                                  |                   |                       | 15 mo                                       | 11                |
|                     | /Medical<br>Examiner  |                  | rooming in dodiny   | - (                       | Due to (or                               | ás a consequ   | uence of):   |                            |                    |               |                 |                                  |                   |                       |   |                   |
| ١.                  |   | _                | Sequentially list condition if any, leading to immediately cause. Enter Underlyin | ons,                      | b. Due to (or                            | as a consequ   | nence off.   |                            |                    |               |                 |                                  |                   |                       |   |                   |
| الك                 | ted<br>nsit   | nin              | cause. Enter Underlyin<br>Cause (Disease or injur                                 | g ⊀                       | 240 10 (01                               | ao a 55113041  | aci 100 01).   |                            |                    |               |                 |                                  |                   |                       |   |                   |
| ~                   | and and al-tra  | Examine          | that initiated events<br>resulting in death) Last                                 |                           | c. Due to (or                            | as a consequ   | uence of):   |                            |                    |               |                 |                                  |                   |                       |   |                   |
| 8760,               | iaw requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit  | calE             |   | · ·                       |  |                |  |                            |                    |               |                 |                                  |                   |                       |   |                   |
| 687                 | ficate<br>physics the   |                  |   |                           | a  |                |  |                            |                    |               |                 |                                  |                   |                       |   |                   |
| Вох                 | eath certific<br>attending p  | Physician/Med    | IF FEMALE:<br>23b. Was decedent pre   | onant                     | 23c. If yes, outcome                     |                |  |                            |                    |               |                 |                                  | 23d. l            | Date of deliv         | verv  |                   |
| ă                   | death<br>atte   | ciai             | in the past 12 mon  | nths?                     | 1□Live birth<br>4□Pregnan                |                |  | Ectopic pro<br>Other (spe  |                    |               |                 |                                  |                   | Month                 |   | ear               |
| 0                   | at the de<br>by the a<br>tached   | hysi             | 9 Unknown   | <u></u>                   | 9□ Unknow                                | ו              |  |                            | •                  |               | _               |                                  |                   |                       |   |                   |
| 0                   | s that<br>ned b<br>a deta   | by P             | Part II. Other significan   | nt conditions             | ontributing to deat                      | h but not resi | ulting in the u  | nderlying ca               | ause give          | en in Part I. |                 | 23e. Did to                      | bacco use co      | ontribute to          | the cause of de                             | ath?              |
| rds                 | quires<br>in sign<br>uld be   |                  |   |                           |  |                |  |                            |                    |               |                 | 187                              | es 2□No           | 3 🗆 Pro               | obably 4 □Ur                                | ıknown            |
| Records,            | aw requir<br>as been si<br>2 should I   | oleted           |   |                           |  |                |  |                            |                    |               |                 | 24a. Was                         | an 24             | o. Were aut           | topsy findings a                            | vailable          |
| Re                  | e his   | отр              |   |                           |  |                |  |                            |                    |               |                 | autop                            | med?              | prior to co<br>death? | completion of car                           | use of            |
| Vital               | sicien: T<br>certificat<br>irector, pa  | e C              | 25. Was case referred t   | to medical                |  |                |  | -                          |                    | 26. Place     | of Death        | 1 ☐ Yes<br>(Check only o         | 2 No              | 1 🗆 Yes               | 2 <sup>t</sup> □ No                         |                   |
| <u> </u>            | Physicien:<br>this certific<br>ral director,  | o<br>B           | examiner?<br>1 ☐ Yes 2 ☐ №  |                           | Hospital:                                | atient 2       | ER/Outpatien   | t 3 DO                     | A Othe             | >r**          |                 | ne 5 Resid                       |                   | Other (Spec           | :ifv)                                       |                   |
| ) of                |   | L:u              | 27. Manner of Death   |                           | 28a. Date of I                           |                | 28b. Time of   |                            | Bc. Injury<br>Work |               |                 | 8d. Describe h                   |                   |                       | ,   |                   |
| Ö                   | 불교육회  | atlo             | 1 Natural 5 2 ☐ Accident  | ☐ Pending investigation   |  | Day (Gai)      | Injury   | М                          |                    | res 2 1       | No              |                                  |                   |                       |   |                   |
| Division            |   | tific            | 3 ☐ Suicide 6<br>4 ☐ Homicide   | Could not b<br>determined | 286. Place of                            | Injury - At ho | ome, farm, str   | eet, factory               | , office           |               | 2               | 8f. Location (S<br>City or Tow   |                   | nber or Rui           | ral Route Numb                              | er,               |
| Ö                   | tel or A<br>s after<br>el Dire<br>ed in by  | Certification:   |   |                           | Dullang,                                 | Oto. (Opoon)   | ''   |                            |                    |               |                 | Only of Ton                      | n, otate/         |                       |   |                   |
|                     | To the Hospitel or within 24 hours after To the Funerel Dir completely filled in  | edical (         | 29a. Certifier 1 (Check only 2  | Certifying Ph             | ysician: To the be<br>niner: On the basi | st of my kno   | wledge, death  | occurred a                 | at the tim         | e, date and   | d place, a      | and due to the                   | ause(s) and       | manner as             | stated.                                     |                   |
|                     | the Lin 24<br>the F   | edi              | one)  |                           | and manner                               | stated.        | and/or in  |                            |                    |               | occurre         | at the time, (                   | and bigo          | s, ariu due           | to the cause(s)                             |                   |
|                     | To To I   | Σ                | 29b. Signature and title  | et certifier              |  | 13             |  | 29c.                       | . License          | number        |                 |                                  | 29d. Date sign    |                       |   | r <sub>oj</sub> . |
| •                   | -   |                  | 1/1/  | ME                        | de                                       | 20             |  |                            | P                  | 315           | 5               | / /                              | Jeces             | rber                  | 2420  | 105               |
|                     | EXI   |                  | 30. Name and address  | of person who             | completed cause of                       | of death (Item | 23a) (Type,  | Print)                     | 1                  | - 1           | 0               | <u> </u>                         |                   | Ω                     | 22,20                                       | , , )             |
|                     | 5   |                  | Whisza  | SHOP NO                   | 1)elie                                   | w10            | 30   | 3 >                        | 105                | p. fe         | 4 1             | DWG,                             | Opa               | Jun                   | 1201.210                                    | 10(               |
|                     | Sta   | -                | 31. Date filed (Month, D  | -                         | 2. Reg                                   | strar's Signa  | ture   | 160                        |                    | 0             |                 |                                  |                   |                       | 9   | 1.                |
| a.                  | Registr   | ar               | DEC 2   | C 1 700:                  |  |                | A STATE OF THE PARTY OF THE PAR |                            |                    |               |                 |                                  |                   |                       |   |                   |

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|   |  | 1              | For<br>Stata<br>Registrar                                     |                           | St           | tate of M   | larylar                     |                            | artmen<br>rtificate        |                          |                                       | and M                   | lental Hy                              | gien<br>Reg: No |   | 41763   |
|---|--|----------------|---|---------------------------|--------------|---|-----------------------------|----------------------------|----------------------------|--------------------------|---------------------------------------|-------------------------|--|-----------------|---|---|
|   | Physicia<br>/Medica  | in<br>al       | 1. Decedent's Name  | AA                        | A            | BD0   |                             |                            |                            |                          |                                       |                         | 2. Date of De<br>Month<br>December     | ERDa            | Yag Zoo                                     |   |
|   | Examine  | er             | 4a. Facility Name (I  | CARE C                    |              |   | )                           |                            |                            |                          | Location o                            |                         |  |                 | BALTIMO                                     |   |
|   | Funeral  |                | 5. Social Security N  | lumber                    | 6. Sex       | 7. A  |                             | last birthday)             | If Under<br>Months         |                          |                                       |                         | 8. Date of Bir<br>(Month, Da<br>02/21/ |                 |   | thplace (State or Foreign                               |
| #   | Director   |                | 218-48 Usual Residence of                                     |                           | 1 X M        |   | 87                          | Yrs.                       |                            |                          |                                       |                         | 02/21/.                                | 1918            |   | ÉGYPT   |
|   | ahow<br>ahow   |                | 10a. State  | 10b. County               |              |   |                             | ty, Town or L              |                            |                          |                                       |                         |  |                 |   | 10d. Inside City Limits                                 |
|   | the Ma   | Director       | MD<br>10e. Street and Nu                                      | BALTIM                    | IORE_        |   | BAI                         | LTIMOR                     | 10f. Zip                   | Code                     |                                       |                         |  | 10a C           | itizen of What C                            | 1 Yes 2 No  |
|   | 3a or  |                |   | COURT                     | ROAD         | #720  |                             |                            | TOI. ZIP                   |                          | 208                                   |                         |  |                 | .S.A.                                       | outiny.   |
| 936   | be filed within 72 hours after death with the Maryland atal Hygiene. ad other then "naturel", or Itema 23e or 28e-f ehow event, Ira Mesical Examiner matte malling | by Funeral     | 11. Marital Status 1 ☐ Never Marr 3 🂢 Widowed                 | ied 2□ Marn               | 12. V        | Was Decedent<br>Armed Forces<br>Yes 27<br>1 Yes, Give X<br>Year or Dates: | ?<br>] No                   | .S. 13.                    | Was Deced<br>If Yes, spec  |                          | spanic Ori<br>n, Mexicar<br>Specify:  | gin? (Spo<br>, Puerto   | ecify Yes or No<br>Rican, etc.)        |                 | 14. Race - Am-<br>Black, Whi<br>Specify: Wh | te, etc.  |
| 5-0   | 72 ho  | eted           | (Spec   | 15. Decedent              | s Educatio   | n<br>mpleted)   |                             | (Give                      | dent's Usua<br>kind of wo  | k done c                 | <i>lurina</i> mos                     | t of work               | ing                                    | 16b. F          | Kind of Business                            | /Industry   |
| ABDOU<br>21215-0036   | within<br>iene.<br>'then'  | Completed      | Elementary/Seco   |                           | 0            | College (1-4or  | 5+)                         | FACTO                      | DO NOT US                  |                          | )                                     |                         |  | М               | ATTRESS                                     |   |
|   | be filed tal Hygie d other   | Be C           | 17. Father's Name   |                           | Last)        |   |                             | 1171010                    |                            |                          | 18. Mothe                             | er's Name               | e (First, Middle                       |                 |   |   |
| LICHAA<br>Maryland  | should be<br>nd Mental<br>i marked o   | 2              | ABDOU   |                           |              |   |                             | LIC                        |                            |                          | RACH                                  |                         |  |                 |   | NKNOWN  |
| Mar   | 0 40 = 6   | İ              | 19a. Informant's N  |                           |              | Print)<br>JGHTER  |                             | 1                          |                            |                          |                                       |                         |  |                 | o <i>r Town, Stat</i> e,<br>TOWN , MI       |   |
|   | s 1 and<br>f Health<br>item 27<br>other tr   |                | 20a. Method of Dis  | position                  |              |   | 20b. I                      | Place of Disponentery, cre |                            |                          |                                       |                         | Date                                   |                 | ocation - City or                           |   |
| 10<br>10<br>10<br>10<br>10<br>10<br>10<br>10<br>10<br>10<br>10<br>10<br>10<br>1 | Pages<br>ment of<br>ant: If It<br>ury or o   |                |   | ☐Cremation<br>S☐Other (S) |              | oval from State   | 9                           | AR SIN                     |                            |                          | 1                                     | 2/27                    | /2005                                  | OWI             | NGS MILI                                    | LS, MD  |
| SAID TO BE Baltimore,   | permit. Pag<br>Department<br>Important: t<br>eny injury o  |                | 11/1/   | ineral Service            |              |   |                             | 1                          | 2. Name an                 |                          |                                       | _ SU                    | L LEVI                                 | NSON            | & BROS                                      | ., INC.   |
| S =   | an = o u   | 4              | 22a. Fart1. Enter t   | the disease, or           | complication | ns that cause   | ed the dea                  | th. Do not en              | 8900 I                     | REIS<br>e ol dyin        | TERST<br>g, such as                   | OWN<br>cardiac          | ROAD -                                 | PIK<br>arrest,  | ESVILLE                                     | MD 21208  |
|   | Physician  |                | shock, or heat<br>Immediate Cause<br>disease or condition     | (Final                    | only poe ca  | DA O  | CRE                         | ATIC                       | (                          | AR                       | CIN                                   | on                      | H.                                     |                 |   | Interval Between<br>Onset and Death                     |
|   | /Medical<br>Examiner   |                | resulting in death)   | JII                       | a            | Due to (or a  | C                           |                            |                            |                          | · · · · · · · · · · · · · · · · · · · |                         |  | <del></del>     |   |   |
|   |  | _              | Sequentially list co<br>if any, leading to in                 | onditions,                | b            | Due to (or a  | s a consec                  | tuence of):                |                            |                          |                                       |                         |  |                 |   |   |
| 10  | uted<br>d<br>ansit   | Examiner       | cause. Enter Under Cause (Disease or that initiated events    | eriying<br>injury         | <b>.</b>     | 20010 (0. 0   |                             | (441100 01).               |                            |                          |                                       |                         |  |                 |   |   |
| Ó   | be executed<br>sicien and<br>burial-transit  |                | resulting in death)   |                           | L            | Due to (or a  | s a consec                  | quence ol):                |                            |                          |                                       |                         |  |                 |   |   |
| 8760  | # × 6  | dicai          |   |                           | d            |   |                             |                            |                            |                          |                                       |                         |  |                 |   |   |
| P.O. Box 68   | Physician: The law requires that the death certificat: this certificate has been signed by the attending phyral director, page 2 should be detached for use as the | Physician/Med  | IF FEMALE: 23b. Was deceder in the past 12 1 Yes 26 9 Unknown | months?                   |              | if yes, outcom<br>1 □ Live birth<br>4 □ Pregnant<br>9 □ Unknown           | 2 Feta                      | aldeath 3                  | □Ectopic pr<br>□ Other (sp |                          |                                       |                         |  |                 | 23d. Date of de<br>Month                    | olivery<br>Day Year                                     |
| rds, P.   | w requires that been signed by should be deta  | þ              | Part II. Other signi  | ficant condition          | ens contribu | uting to death  | but not re                  | sulting in the (           | underlying o               | ause give                | en in Part I                          |                         |  |                 | use contribute t                            | o the cause of death?                                   |
| Division of Vital Records,  | eician: The law re<br>certificate has bee<br>irector, page 2 sho   | Completed      | - :   |                           |              |   |                             |                            |                            |                          |                                       |                         | 24a. Was<br>auto<br>perf<br>1 Yes      |                 | prior to death?                             | utopsy findings available completion of cause of s 2 No |
| Vita  | ician:<br>certific<br>ector.   | Be             | 25. Was case reference examiner?                              | /                         | Hosp         | ıtal: :   |                             |                            |                            | Othe                     | ar M                                  | V.                      | h (Check only                          |                 |   |   |
| ō   | Physe<br>eral di   | 2              | 1 Yes 2 2   | th                        | 2            | 1   Inpat<br>8a. Date of In<br>(Month, D                                  |                             | 28b. Time of               |                            | 8c. Injun<br>Worl        | 4/2 140                               |                         | me 5∐ Res<br>28d. Describe             |                 | 6 □Other (Speury occurred                   | əcify)  |
| ion   | Attending F<br>death.<br>ctor: After<br>y the funer.   | atlo           | 1 Natural 2 Accident  | 5 Pendin<br>investig      | ation        | (Month, D   | ay rear)                    | Injury                     | М                          |                          | Yes 2                                 | No                      |  |                 |   |   |
| Divis   | To the Hospitel or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the fune   | Certification: | 3 ☐ Suicide<br>4 ☐ Homicide                                   | 6 Could determ            |              | 8e. Place of In<br>building, e  | njury - At h<br>etc. (Speci | nome, larm, st             | reet, lactory              | r, office                |                                       |                         | 281. Location (<br>City or To          |                 |   | lural Route Number,                                     |
|   | To the Hospitel of within 24 hours af To the Funeral D completely filled in  | edical         | 29a. Certifier<br>(Check only<br>one)                         | 1 Certifyin<br>2 Medicai  | Examiner:    | on: To the bes<br>On the basis<br>and manner s                            | ot examin<br>stated.        | ation and/or ii            | rvestigation               | at the tim<br>, in my of | ne, date ar<br>pinion, dea            | nd place,<br>ith occuri | and due to the<br>red at the time      | , date ar       |   | e to the cause(s)                                       |
|   | Vith<br>To To  | Σ              | 29b. Signature and  |                           | 14           | anah  |                             | YSICIF                     |                            | DI                       | number<br>227                         | 23                      |  | D & C           |   | 22192005  |
|   | 7  |                |   |                           | who comple   | eted cause of   | death (Ite                  | т 23а) (Туре               | Print) S<br>RAN            | DAL                      | E 3                                   | 500 i                   | 1 men                                  | OICP            | IL BUIL                                     | 0 21133   |
|   | Sta<br>Registr   | 10.0           | 31. Date filed (Mor   | C 2 8 2                   | 2005         | 37 Hegis  | itrar's Sign                | arure                      | W.                         |                          |                                       |                         |  |                 |   |   |

#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Lest) 2. Date of Death Month Day Year **Physician** 3:10 pm 0 Dec 0005 /Medical 4a. Facility, Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner NIA Dalte uchearn more 7. Age (In yrs. last birthday) Yrs. If Under 1 Year Months Deys Birthplace (State or Foreign Country) 6. Sex 8. Date of Birth (Month, Dey, Year) 5. Social Security Number 1MM 20 F 214-16-7490 naryland Usual Residence of Decedent 10d. Inside City Limits 10a, State 10b. County 10c. City, Town or Location 1⊠Yes 2□No Funeral Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code SA 2501 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) Race - American Indien, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Completed by 3 ☐ Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Taclop Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be UNNI a ဥ 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Coronado 20b. Place of Disposition (Name of cemetery, cremetory or other p ce 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation \_ 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Add 701 jan finarch runeral Home. Balto, md, 21229 23a. Part. the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or leart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) er outlet obsti Due to (or as e consequence of): Physician/Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of): Due to (or as a consequence of): tract infection Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobecco use contribute to the ceuse of deeth? 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Completed performed? 1 Yes 2. No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? B 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 20 No ို 1 🗌 Yes 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident

Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician Division of Vital Records, ate has this Director: After t d in by the funera within 24 hours aft To the Funerel Discompletely filled in

**Physician** 

/Medical

**Funeral** 

Director

oriant: if item 27 is marked other than "netural", or items 23a or 28a-f show injury or other traumatic event, the Medical Evanti at must be notified at

Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene.

Baltimore, Maryland 21215-0020

ROWN

Certification: Medical

3 Suicide 6 Could not be determined 4 Homicide

29b. Signature and title of certifier

29a. Certifier

investigation

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 413 commonwealth AV, contonsville, un

Willie B. MVENBA, MI) 32. Registrar's Signature 31. Date filed (Month, Day, Year) DEC 2 8 2005

State Registrar

|            |   |                  | . For   |   | laryland / Dep   |   |   | •  | •                                  | Die.   |
|------------|---|------------------|---|---|--|---|---|--|------------------------------------|--|
|            |   |                  | 1 - State<br>Registrer  |   | Ce   | rtificate of                                    | Death                                       | R  | () Con por                         | 5 41765  |
|            | Physici   | an               | Decedent's Name (First, Middle, La  | st)   |  |   |   | 2. Date of Dea<br>Month                  | Day                                | 3. Time of Death   |
|            | /Media  | cal              | 4a. Facility Name (If not institution, giv  | a street and number   | -)   | 4b City Town o                                  | r Location of Death                         | 12                                       | 26 2<br>4c. County                 | 2005 1715 PM   |
|            | Examir  | ıer              | University of Ma  |   |  |   | more  |  | N/A                                |  |
|            | Funeral   |                  | 5. Social Security Number 6. S  | Sex 7. A  | ge (In yrs. last birthday  |   | If Under 24 Hrs.<br>Hours Min.              | 8. Date of Birth                         |                                    | Birthplace (State or Foreign Country)  |
|            | Director  |                  | 210-02-3200   | I □ M 2 💢 F   | 66 Yrs.  | Months Days                                     | Hours will.                                 | 08/05/                                   | 1939                               | N. CAROLINA  |
|            | land<br>ow  |                  | Usual Residence of Decedent 10a. State 10b. County  |   | 10c. City, Town or L   | ocation   |   |  |                                    | 10d. Inside City Limits  |
|            | Mary<br>Be-1 eh   | tor              | MD N/A  |   | BALTI  | MORE CI   | ГҮ  |  |                                    | 1 XYes 2 □ No  |
|            | ours after death with the Maryland<br>ral', or iteme 23a or 28e-1 ehow<br>Examiner must be notified at                                      | ai Director      | 10e. Sfreef and Number 4007 WOODMERE  | E AVENUE  |  | 10f. Zip Code<br>2121                           | 5   | 1  | Og. Citizen of V<br>USA            |  |
|            | r dea   | Funeral          | 11. Marital Status  | 12. Was Decedent<br>Armed Forces                                | t Ever in U.S. 13.   | Was Decedent of H                               | lispanic Origin? (Sp<br>an, Mexican, Puerto | ecify Yes or No-                         | 14. Rac                            | ce - American Indian,<br>ck, White, etc.                                     |
| 36         | hours after<br>tural', or ite   | by F             | 1 ☐ Never Married 2 ☐ Married  3 🔀 Widowed 4 ☐ Divorced   | 1 ☐ Yes 2√☐<br>ff Yes, Give<br>Year or Dates:                   | X₁o  | 1 ☐ Yes <b>X</b> ☐ No                           | Specify:                                    |  |                                    | BLACK  |
| 5-0036     | 2 3 7   |                  | 15. Decedent's E  | ducation  | 16a. Dece  | dent's Usual Occup                              | ation                                       |  | 16b. Kind of Bu                    | usiness/Industry   |
| 2          | within 72<br>ene.<br>then "na   | Completed        | (Specify only highest gra   | College (1-4or  | life.  | DO NOT use retired                              | during most or work<br>d)                   | ang                                      | HOOD                               | CDDUTCD  |
| 2          | Hygier<br>Hygier<br>Ther th   |                  | 12TH<br>17. Father's Name (First, Middle, Last,   | )   |  | COOK  | 18. Mother's Nam                            | o /First Middle                          |                                    | SERVICE  |
| au         | d be f<br>ental l   | To Be            | MILTON HILL   |   |  |   | BETTY                                       |  | Malueri Suriali                    |  |
| Maryland   | should<br>and Mer<br>marke<br>umatic  | 1-               | 19a. Informant's Name/Relationship (  | Type, Print)  | 19b. Mail  | ng Address (Street                              |   |  | r, City or Town,                   | State, Zip Code) 21225   |
|            | and 2<br>ealth a<br>n 27 i  |                  | DELORISE WOODS  | DAUGI   | The state of the s | BETHUNE   |   |  |                                    | MORE, MD   |
| Baltimore, | Pages 1 an<br>nent of Heal<br>int: if item 2<br>iry or other  |                  | 20a. Method of Disposition  **DBurial 2   Cremation 3   | Removal from State  |  | matory or other plac                            | ce)   |  |                                    | City or Town, State  |
|            | . 5 2 4   |                  | 4 □ Donation 5 □ Other (Specifical Service Licer  |   |  |   |   |  |                                    | ORE CO., MD  |
| g          | permit<br>Depar<br>Impor<br>eny in  |                  | 21. Signature V. Ignieral Service Little  | 78. N   | aut !  | 4600 LIE  | SERTY HE                                    | WELL F                                   | UNERAL<br>AVE. B                   | HOME 21207<br>ALTIMORE, MD   |
| 6          |   |                  | 23a. At Effer the Lease, or come spock, or heart liure. List only   | plications that cause   |  |   |   |  |                                    | Approximate<br>Interval Between  |
|            | Physician   |                  | fmmediate ause (Finat   |   | blood 10   |   |   |  |                                    | Onset and Death  |
|            | /Medical<br>Examiner  |                  | resulting in death)   | Due to (or as   | s a consequence of):   |   |   |  |                                    |  |
| 4          | <b>A</b> . A.   | -                | Sequentially list conditions, if any, leading to immediate  |   | s a consequence of):   | astric t  | umor  |  |                                    |  |
|            | uted<br>d<br>ansit  | Examine          | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events |   | _  |   |   |  |                                    |  |
| Ď,         | be executed<br>sician and<br>burial-transit   |                  | resulfing in death) Last  | Due to (or as   | s a consequence of):   |   |   |  |                                    |  |
| 68760      | 2 0   | dicai            | •   | d   |  |   |   |  |                                    |  |
|            | death certifica<br>e attending phy<br>of for use as th  | by Physician/Med | IF FEMALE:  | 23c. ff yes, outcome  | e of pregnancy   |   |   |  | 22d Day                            | a of delivery  |
| ROX        | death<br>a atter<br>d for u   | iciar            | 23b. Was decedent pregnant<br>in the past 12 months?<br>1 □ Yes 2 ☑ No  | 1 ☐ Live birth  | 2 Fetal death 3  | □Ectopic pregnancy<br>□ Other (specify)         | <u>'</u>                                    |  | Moi                                | te of delivery<br>nth Day Year   |
| Į.         | at the<br>by the<br>tache   | hys              | 9 Unknown   | 9□ Unknown  | ·  |   |   |  |                                    | -  |
| -          | requires that the<br>een signed by th<br>nould be detache   |                  | Part II. Other significant conditions of  | ontnbuting to death I   | but not resulting in the u   | inderlying cause give                           | en in Part I.                               |  |                                    | ribute to the cause of death?  |
| Hecords    | requi   | Completed        |   |   |  |   |   | 1 🗆 Ye                                   |                                    | 3 Probably 4 Unknown   |
| ě          | e 0 01  | mpl              |   |   |  |   |   | 24a. Was a autops                        | v r                                | Were autopsy findings available<br>prior to completion of cause of<br>death? |
| VII        |   | e<br>လ           | 25. Was case referred to medical  |   |  |   | 00 Bloom (Brown                             |  | 2 No 1                             | I ☐ Yes 2 ☐ No   |
|            | > 0 0   | To B             | examiner?<br>1 ☐ Yes 2 X No   | Hospital: 1 Inpati  | ient 2 ☐ ER/Outpatie   | nt 3 DOA Oth                                    | er: 4 ☐ Nursing Ho                          | me 5 ☐ Reside                            |                                    | er (Specify)   |
| ם כו       | ng Phys<br>fter this<br>ineral di   |                  | 27. Manner of Death 1/⊠Naturaf 5 □ Pending  | 28a. Date of Inju   |  | f 28c. Injun<br>Worl                            |   | 28d. Describe ho                         |                                    |  |
| UIVISION   | Attending<br>ir death.<br>ector: After<br>by the fune   | cati             | 2 Accident investigation 3 Suicide 6 Could not be   |   |  | M 1 🗆   | Yes 2 □No                                   |  |                                    |  |
| 2          | al or A<br>after<br>i Direc<br>d in by  | Certification;   | 4 ☐ Homicide determined   | building, e   | ijury - At home, farm, st<br>tc. (Specify)   | reet, factory, office                           |   | City or Town                             | reet and Number,<br>State)         | er or Rural Route Number,  |
|            | To the Hospital or Attending Ph<br>within 24 hours alter death.<br>To the Funerel Director. After th<br>completely filled in by the funeral | edical (         | 29a. Certifier 1 Certifying Ph<br>(Check only one) 2 Medical Exam   | ysician: To the best<br>niner: On the basis of<br>and manner st | t of my knowledge, deat<br>of examination and/or in<br>tated.  | h occurred at the time<br>vestigation, in my of | ne, date and place,<br>pinion, death occur  | and due to the ca<br>red at the time, da | ause(s) and ma<br>ate and place, a | nner as stated.<br>and due to the cause(s)                                   |
|            | To ti<br>Withi<br>To ti<br>comp   | ž                | 29b. Signature and title of certifier   | // _  |  | 29c. License                                    | e number                                    | 2  | 9d. Date signed                    | d (Month, Day, Year)   |
| 1          | 0   |                  | MULKUM  | (M)   |  |   | 6435S15                                     | 5802                                     | 12/26                              | 12005  |
|            | 3   |                  | 30. Name and address of person who  |   | 0.   |   | t 4 0~                                      | MD                                       | 2120                               | 2)   |
| 23         | Sta   | te               | 31. Date filed (Month, Day, Year)   |   | rar's Signature  | •   | timore                                      | 1117                                     | 212                                |  |
|            | Registr   |                  | DEC 2 8 3   | 2005  | de 1   | racks   |   |  |                                    |  |

DHMH 17 Rev 1/2001

**ORIGINAL** 

|   |                | . For   | State of                                 | f Marylan  |                            |  |                      |                         |   | _                              |                             | gible.                         | 1 1 2 2 1 2                                      |
|---|----------------|---|--|--|----------------------------|--|----------------------|-------------------------|---|--------------------------------|-----------------------------|--------------------------------|--|
|   | •              | 1 - State<br>Registrar  |  | ,  | Ce                         | rtificate                                  | of L                 | Death                   |   |                                | Reg. No.                    | UD                             | 41/00  |
| Physici   | an.            | 1. Decedent's Name (First, Middle   |  |  |                            |  |                      |                         |   | 2. Date of De<br>Month         | Day                         | Year                           | 3. Time of Death                                 |
| /Medi   |                | James A   |  | SER.   |                            | 4b City T                                  | OWD OF               | Location o              | d Death                                 | DEC                            | 22<br>4c COU                | 2005<br>inty of Death          | 0250 M   |
| Examir  | ner            | 4a. Facility Name (If not institution Howard Count  | y Gonerou                                |  | 1.1                        |  |                      | bio                     | Death                                   |                                |                             | OWAYO                          | 1  |
| Funeral   |                | 5. Social Security Number   | -6. Sex                                  | 7. Age (In yrs.  |                            | If Under 1                                 |                      | If Under                | 24 Hrs.                                 | 8. Date of Bir<br>(Month, Da   | th                          |                                | place (State or Foreign                          |
| Director  |                | 219. 78. 9010   | 1 <b>®</b> M 2□F                         | 39   | Yrs.                       | MONTHS                                     | Days                 | riours                  | Willi.                                  | 03.09.                         | 1966                        |                                | MD   |
| and   |                | Usual Residence of Decedent  10a. State 10b. County   |  | 10c. Cit   | ty, Town or Lo             | ocation                                    |                      |                         |   |                                |                             | 1                              | 10d. Inside City Limits                          |
| Maryl<br>-1 eho<br>lied s   | ţŏ             | MD HOWAR  | 2D                                       | EIII   | con c                      | ITV  |                      |                         |   |                                |                             |                                | 1 ☐ Yes 2 👿 No                                   |
| th the or 28a anott   | Director       | 10e. Street and Number  |  |  | 00.1                       | 10f. Zip (                                 | Code                 |                         |   |                                | 10g. Citizen                | of What Cour                   | ntry?  |
| ath wi  | rai            | 5231 FONT A   | NENUE                                    |  |                            |  | 2104                 |                         | : 0.10                                  | 7 1/2                          | 14.1                        | USA                            | onn Indian                                       |
| OUSS hours after death with the Maryland hours of tems 23a or 28a-1 show at Examiner must be notified at  | Funeral        | 11. Marital Status  1 Married 2 Mar | Armed Fo                                 |  | .S. 13.                    | Was Decede<br>If Yes, speci                | ont of Hi<br>fy Cuba | ispanic Origin, Mexican | gin? (Spe<br>i, Puerto f                | cify Yes or No<br>Rican, etc.) | )- 14.1                     | Race - Americ<br>Black, White, |  |
| urs aft   | byF            | 3 ☐ Widowed 4 ☐ Divorced  | If Yes, Gi<br>Year or D                  | ve   |                            | 1 ☐ Yes 2                                  | No No                | Specify:                |   |                                | Spe                         | BLA                            | ick .  |
| Z15-UU36 thin 72 hours af e. in "natural", or   | eted           | 15. Deceden   | t's Education                            |  | 16a. Dece                  | dent's Usual<br>kind of work<br>DO NOT use | Оссира               | ation<br>during most    | t of workin                             | ng                             | 16b. Kind o                 | f Business/In                  | dustry   |
| Athin Athin   | Completed      | Elementary/Secondary (0-12)   | College (                                | 1-4or 5+)  |                            |  |                      | NAGE                    |   |                                | DE                          | TAIL                           |  |
| d Z1Z1  | ပ္ပ            | 12 11 GRADE  17. Father's Name (First, Middle,  | Last) 3 YF                               | (3   | TRAL                       | OUIUG                                      | MA                   |                         | -                                       | (First, Middle                 |                             |                                |  |
| d be entail ked o   | To Be          | LEONARD SAMUE   |  | R  |                            |  |                      | SHERI                   | DINA                                    | BROK                           | IN                          |                                |  |
| Maryland d 2 should be fill th and Mental H; 7 Is marked out treumatic even   |                | 19a. Informant's Name/Relations   | hip (Type, Print)                        |  | 19b. Maili                 | ng Address                                 |                      |                         |   | i Route Numb                   |                             | wn, State, Zip                 | Code)  |
| C = 44 P  |                | SHERDINA MAR  | VIN (MO)                                 | HER)   |                            | REEDB                                      |                      | AVE                     |   | ALTO. N                        |                             | 225                            |  |
| Ore<br>of H<br>if Itar  |                | 20a. Method of Disposition 1 ☐ Burial 2 🐼 Cremation   | 3 ☐Removal from                          | State  | Place of Disponentery, cre | matory or other                            | e of<br>her plac     | - 1                     |   | ate                            |                             | on - City or To                |  |
| Baltim permit. Pag Department Important: any injury o   |                | * 4 □ Donation 5 □ Other (S<br>21. Signature of Funeral Service   |  | GRE  | ENMOL                      |  | Addras               |                         | 2.27                                    | .05                            | BALTIN                      | loke,                          | MD   |
| Balt permit. Depart Import any inj  |                | 21. Signature of Funeral Service  | Colisoo                                  |  | CE                         | 2. Name and<br>EMATIC<br>51 BALT           | N S                  | ERVICE                  | S<br>JE E                               | 3A170. M                       | 0 2122                      | a                              |  |
|   |                | 23a. Part1. Enter the disease, or shock, or heart failure. List   | complications that                       | caused the dea   |                            |  |                      |                         |   |                                |                             |                                | Approximate<br>Interval Between                  |
| Physician   |                | Immediate Cause (Final disease or condition   | only one cause on                        | Pneun  | ronla                      |  |                      |                         |   |                                |                             |                                | Onset and Death                                  |
| /Medical  |                | resulting in death)   | Due to                                   | (or as a consec  |                            |  |                      |                         |   |                                |                             |                                | 1  |
| Examiner  | _              | Sequentially list conditions,   | b  | Sepst.   | 5                          |  |                      |                         |   |                                |                             | -                              | May s.   |
| ed<br>1sit  | Examiner       | Sequentially list conditions, in any, leading to infiliationate cause. Enter Underlying Cause (Disease or injury  | Divers                                   | Metas L  | abi C.                     | And  | 1                    | saro                    | inne                                    | ma                             |                             |                                | months   |
| execut<br>n and<br>al-trae  | Ехап           | that initiated events<br>resulting in death) Last   | c.<br>Due to                             | (or as a consec  | quence of):                | 7 - 7 - 0                                  |                      | (0)                     | ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, |                                |                             |                                |  |
| 58760,<br>icate be executed<br>physicien and<br>s the burial-transit  | cai            |   | d  |  |                            |  |                      |                         |   |                                |                             |                                |  |
| - O es  | Physician/Medi | IF FEMALE:  |  |  |                            |  |                      |                         |   |                                |                             |                                |  |
| BOX<br>eath cert<br>attendin<br>for use   | lan/           | 23b. Was decedent pregnant in the past 12 months?   | 1 Live                                   | itcome of pregn<br>birth 2 ☐ Feta<br>nant at time of c | al death 3                 | ☐Ectopic pre☐ Other (spe                   |                      | /                       |   |                                | 23d.                        | Date of delive<br>Month        | ery<br>Day Year                                  |
| IS, P.O. I  | ysic           | 1 □ Yes 2 □ No<br>9 □ Unknown   | 9□ Unki                                  |  | 394(1)                     | _ O(I) 61 (3pc                             |                      |                         |   |                                |                             |                                | _  |
| s that  | by Pr          | Part II. Other significant condition  |  |  |                            |  |                      | en in Part I            |   | 23e. Did                       | tobacco use                 | contribute to t                | the cause of death?                              |
| cords w requires been sig   | ed b           | Human In  | rmuno de                                 | ti cim   | ay                         | Viru;                                      | 2                    |                         |   | 10                             | Yes 2□N                     | o 3 Prot                       | bably 4 Tunknown                                 |
| ecor<br>law requ<br>as been<br>2 should   | piet           |   |  |  |                            |  |                      |                         |   | 24a. Was                       | psy                         | prior to co                    | opsy findings available<br>empletion of cause of |
| Vital Rec<br>sician: The law<br>s certificate has t<br>lirector, page 2 s   | Completed      |   |  |  |                            |  |                      |                         |   |                                | ormed?<br>2 ☐ No            | death?                         | 2 □ No   |
| Division of Vital Records, for Attending Physicien: The law requires the after death.  Director: After this certificate has been signe in by the funeral director, page 2 should be death.            | Be             | 25. Was case referred to medica examiner?   | Hanniel                                  |  |                            |  | _ Oth                | 000                     |   | (Check only                    |                             |                                |  |
| on of<br>ding Phys<br>After this<br>funeral dir   | T0             | 1 Yes 2 No  | 11.                                      | Inpatient 2 of Injury of, Day Year)                    | 28b. Time                  |  | A Bc. Injur<br>Wor   | 4 1140                  | _                                       | ne 5 🗆 Res<br>28d. Describe    |                             |                                | fy)  |
| On<br>Inding<br>Ith.<br>:: Afte   | tor            | 1 Natural 5 Pendir<br>2 Accident investi  | 19                                       | nth, Day Year)   | Injury                     | М  |                      | rk?<br>Yes 2□           | No                                      |                                |                             |                                |  |
| Division or Attendate death of Director: in by the  | Certification: | 3 ☐ Suicide 6 ☐ Could<br>4 ☐ Homicide determ  | rined 200. Place                         | e of Injury - At h                                     | nome, farm, s              | reet, factory                              | , office             | ÷                       |   | 28f. Location (                | Street and Ni<br>wn, State) | umber or Run                   | al Route Number,                                 |
| Div<br>ital or A<br>irs after<br>ral Direct   |                |   |  |  |                            |  |                      |                         |   |                                |                             |                                |  |
| Division of Vital Re by the Hospital or Attending Physician: The within 24 hours after death.  To the Funeral Director: After this certificate the completely filled in by the funeral director, page | Medical        |   | ng Physician: To the<br>Examiner: On the |  |                            |  |                      |                         |   |                                |                             |                                |  |
| o the<br>ithin 2<br>o tha   | Med            | 29b. Signature and title of certifie  |  | mier stated.   |                            | 29c  | . Licens             | se number               |   |                                | 29d. Date si                | gned (Month,                   | Day, Year)                                       |
| ⊢ ≯ ⊢ ŏ   |                | * Klanner   | Liai_                                    |  |                            |  | 10-                  | 1289                    | 2                                       |                                | Dec                         | 22                             | 2005   |
| 2.  |                | 30. Name and address of person  | who completed cau                        |  |                            |  |                      |                         |   |                                |                             | -                              |  |
| γ/  |                | Francis Chuic   |  | 724 4  | Hie P                      | ntuxon                                     | f                    | Parku                   | Van                                     | Colu                           | mbia                        | Mn                             | 21044  |
| St<br>Regis   | ate            | 31. Date filed (Month, Day, Year,   | 32.                                      | Registrar's Sign                                       | nature                     | ال الايما                                  |                      |                         | 1                                       |                                |                             |                                |  |
| DHMH 17 Rev 1/  |                | DEC 2 8   | 2005                                     | was to   | Ana                        | A B  |                      |                         |   |                                |                             |                                |  |
| DITITION 1/   | _001           |   |  |  | ORIGIN                     |  |                      |                         |   |                                |                             |                                |  |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Unpend ittem#23a,2/,28a-1, pend 1001,11/06 II

|                     |   |                | 1 - State Registrar  | State of Maryland / Department   | artment of Health artificate of Death                             |  | liene 005 41767  |
|---------------------|---|----------------|--|--|---|--|--|
|                     |   |                | Decedent's Name (First, Middle, Last)  |  |   | 2. Date of Deat                                      | th 3. Time of Death  |
|                     | Physici<br>/Medio   |                | SAUNDRA BOYD   |  |   | DECEMBE:   | R 23, 2005 6:54P.  |
|                     | Examir  |                | 4a. Facility Name (If not institution, give s  | treet and number)  | 4b. City, Town, or Location                                       | of Death   | 4c. County of Death  |
|                     |   |                | ST. AGNES HOSPITAL   |  | BALTIMORE   | 2411   | A M  |
| 0                   | Funeral   |                | 5. Social Security Number 6. Sex   | M ONE  | If Under 1 Year If Under Months Days Hours                        | Min. (Month, Day,                                    | Year) Country)   |
| 3                   | Director  |                | Usual Residence of Decedent  | M 2 Yrs.   |   | 01.02.1  | 952 MD   |
|                     | ehow  |                | 10a. State 10b. County   | 10c. City, Town or Lo  | cation  |  | 10d. Inside City Limits  |
|                     | a-f el  | ctor           | MD NA  | BALTIMOR   | E   |  | 16⊠Yes 2 □ No  |
|                     | or 28   | Director       | 10e. Street and Number   |  | 10f. Zip Code   | 1  | 0g. Citizen of What Country?                                       |
|                     | ath w   | rai            |  | AVENUE   | 21229   |  | USA  |
|                     | e de de   | Funeral        | The state of the s | Armed Forces?  | Was Decedent of Hispanic Or<br>1 Yes, specify Cuban, Mexical      | rigin? (Specify Yes or No-<br>n, Puerto Rican, etc.) | <ol> <li>Race - American Indian,<br/>Black, White, etc.</li> </ol> |
| 36                  | ours after death with the Maryla<br>elf, or iteme 23a or 28a-f ehov<br>Examinat be notified at                        | by F           | 1 ☑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced   | 1 ☐ Yes 2 <b>(X</b> No<br>If Yes, Give<br>Year or Dates:   | 1 ☐ Yes 2 So No Specify:  | :  | Specify: BLACK   |
| Š                   | 72 hours after death with the Maryland<br>Insturet, or fleme 23a or 28a-f ehow<br>clickl Examinational be notified at |                | 15. Decedent's Educ  | ation 16a. Dece  | dent's Usual Occupation   |  | 16b. Kind of Business/Industry                                     |
| 215                 | within 7<br>ene.<br>then "n   | ple            | (Specify only highest grade Elementary/Secondary (0-12)  | Completed) (Give life.   | kind of work done during mos<br>DO NOT use retired)               |  | 2 2  |
| 21                  | be filed within 72 housel Hygiene. Id other then "nature event, the Misclett  | Completed      | 12 TH GRADE  | 3 YRS  | CLERK   |  | SOCIAL SECURITY  |
| Maryland 21215-0036 | be fill<br>d off  | Be             | 17. Father's Name (First, Middle, Last)  |  | l l   | er's Name (First, Middle, M                          |  |
| ž                   | s 1 and 2 should be<br>I Health and Mental<br>Item 27 ie marked o<br>other treumatic eve                              | 2              | ALFRED BOYD  19a. Informant's Name/Relationship (Type  | an Original 10h Maille   |   | RINA HARRIS  | City or Town, State, Zip Code)                                     |
| Ma                  | nd 2 shoulth and 27 ie mu   | 1              | KATRINA H. BOYD  | (MOTHER) 345%  |   |  |  |
| ō,                  | Heal<br>Heal<br>tem 2   |                | 20a. Method of Disposition   | 20b. Place of Dispo  | sition (Name of   | AVE. BALTIN  | 20c. Location - City or Town, State                                |
| ê<br>E              | 00  |                | 1 Ø-Burial 2 ☐ Cremation 3 ☐ Re<br>4 ☐ Donation 5 ☐ Other (Specify)  | emoval from State  Cometery, crer  WOODLAN   | natory`or other place)  | 12/30/05   | BALTIMORE, MD  |
| Baltimore,          | permit. Pag<br>Department<br>Importent: i<br>eny injury o   |                | 21. Signature of Funeral Service License   |  | Name and Address of Facili  |  |  |
| ä                   | 89 E 8 8  |                | Danch C  | 51   | 51 BALTO, NATI  | PIKE BALTO   | . MO 21229   |
|                     |   |                | 23a. Part1. Enter the disease, or complice shock, or heart failure. List only on   | cations that caused the death. Do not ent  |   |  |  |
|                     | Physician   |                | Immediate Cause (Final disease or condition  | Narcotic and alcohol i   | ntoxication   |  | Onset and Death  |
|                     | /Medical<br>Examiner  |                | resulting in death)  | Due to (or as a consequence of):   |   |  |  |
| н                   |   | <u>_</u>       | Sequentially list conditions, if any, leading to immediate   | Due to lor as a consequence of   |   |  |  |
|                     | ted   | Examiner       | cause. Enter Underlying<br>Cause (Disease or injury  | Due to (or as a consequence of)  |   |  |  |
|                     | be executed<br>sicien and<br>burial-transit   | xar            | that initiated events c. resulting in death) Last  | Due to (or as a consequence of):   |   |  |  |
| 8760,               | death certificate be executed<br>e ettending physicien and<br>id for use as the burial-transit                        | dicai          | d  |  |   |  |  |
| 9                   | rtifica<br>ng ph<br>as th   | Medi           | IF FERM F  |  |   |  |  |
| Вох                 | eath certific<br>ettending p  | an/h           | 230. Was decedent program  | Bc. If yes, outcome of pregnancy<br>1□Live birth 2□Fetal death 3□  | Ectopic pregnancy   |  | 23d. Date of delivery  |
| O.                  | at the dea<br>by the et<br>tached fo  | Physician/Me   | in the past 12 months? 1 □ Yes 2 □ No 9전Unknown  |  | Other (specify)   |  | Month Day Year   |
| <u>α</u>            | thet the  | F.             |  | tributing to death but not resulting in the u  | derking cause gwen in Part I                                      | 23a Did toh  | pacco use contribute to the cause of death?                        |
| Records,            | es pe   | d by           |  | thousand to document that the di   | idenying cause given in rait i                                    | 1 □ Ye   |  |
| Ö                   | > 0 0   | leted          |  |  |   | 24a. Was a   |  |
| æ                   | The law ele hes b   | Сотрі          |  |  |   | autops:  | y prior to completion of cause of                                  |
| <u>ra</u>           | ician: T<br>certificet<br>ector, pa   | ပိ             | 25. Was case referred to medical   |  | 26 Place  | e of Death (Check only one                           | !□No 1 Stores 2 □ No   |
| <u> </u>            | Z 2   | To B           | examiner?  | ospital:<br>1 ☐ Inpatient 2 🛱 ER/Outpatien   | Other   | ursing Home 5 Reside                                 |  |
| 0                   |   |                | 27. Manner of Death 1 □ Natural 5 □ Pending  | 28a. Date of Injury 28b. Time of Injury Injury   | 28c. Injury at<br>Work?   | 28d. Describe ho                                     |  |
| <u>Ö</u> .          | Attending r death. sctor; After by the fune   | atic           | 2 ☐ Accident investigation   | 12/23/05 unk   | M 1 ☐ Yes 2 <b>X</b>  | No <b>unk</b>  |  |
| Division of Vital   | i or Attendent<br>efter deatl<br>Director;<br>in by the   | Certification; | 3 Suicide 4 Homicide 6 Tould not be determined   | 28e. Place of Injury - At home, farm, strubuilding, etc. (Specify)   | eet, factory, office  | 28f. Location (Str<br>City or Town                   | reet and Number or Rural Route Number,<br>, State)                 |
|                     | Hospital of the hours of Funerel D (tely filled in  |                | The Coatles III Coatles of the   | found at home  |   | Balt imore.  | 3456W. Caton Avenue  |
|                     | To the Hospital or At within 24 hours efter of To the Funeral Direct completely filled in by                          | ledical        | 25a. Cartifier (Check only one)  1 Certifying Phys. 2 Medical Examin   | <ul> <li>ician: To the best of my knowledge, death<br/>er: On the basis of examination and/or invand manner stated.</li> </ul> | roccurred at the time, date an<br>restigation, in my opinion, dea | id place, and due to the ca                          | use(s) and manner as stated  |
|                     | To the within To the comple   | Me             | 29b. Signature and title of certifier  |  | 29c. License number   | 29   | 9d. Date signed (Month, Day, Year)                                 |
|                     | ->-0  |                | Jan Me.  | Prin   | O.C.M.E   |  | ECEMBER 24, 2005   |
|                     |   |                | 30. Name and address of person who or  | npleted cause of death (Item 23a) (Type,   |   |  | -0 DIE 27, 2007  |
|                     |   |                | Tasha Zareer   |  |   | EET BALTIMORE  | E, MARYLAND 21201  |
|                     | Sta   |                | 31. Date filed (Month, Day, Year)  | Registrar's Signature  | K,  |  |  |
|                     | Registr   | df             | DEC 2 8 2005   | Maria & Signature  |   |  |  |

|                     |   |                  | For<br>1 = State<br>Registrar  | State of M  | Maryland / Depa   | artment of I   |                                     | nd Ment                        | al Hygien                                | UUD                                      | 41768   |
|---------------------|---|------------------|--|---|---|--|-------------------------------------|--------------------------------|--|--|---|
|                     | Physici<br>/Medic   | al               | 1. Decedent's Name (First, Middle,  VIRGIN IR  4a. Facility Name (If not institution,  | 1AZZA   | BAKUT   | 1/5 4b. City, Town,  | or Location of                      | М                              | ate of Death<br>onth Da                  |  | 25- 14:30 M                                       |
|                     | Examin<br>Funeral   | er               | Howard County Ge   | eneral Hos  | pital<br>Age (In yrs. last birthday)                                      | Columbi  | La<br>If Under 24                   | 4 Hrs.   8. Da                 |  | oward                                    | ath irthplace (State or Foreign Country)          |
|                     | Director<br>**Now*  | 4                | Usual Residence of Decedent  10a. State Maryland  10b. County Howard   |   | 92 Yrs.  10c. City, Town or Lo  | ocation  |                                     | Oct                            | 23 191                                   |  | ryland  10d. Inside City Limits  1 □ Yes 2000 No  |
|                     | th with the M<br>23s or 28s-f<br>ast be notifie   | al Director      | 10e, Street and Number<br>3013 Boones Lar  | ne  | EIIICOCC  | 10f. Zip Code<br>2104  | 2                                   |                                | 10g. C                                   | itizen of What C                         |   |
| 920                 | d within 72 hours after death with the Maryland<br>liene.<br>r then "neturel", or Items 23a or 28a-f show<br>the Madical Examinat must be notified at | by Funeral       | 11. Marital Status  1 Never Married 2 Marrie 3 Widowed 4 Divorced  | 12. Was Decede<br>Armed Force<br>d 1 □ Yes 2<br>If Yes, Give<br>Year or Date: | s?<br>No  | Was Decedent of<br>If Yes, specify Cub<br>1 ☐ Yes 2 ☑ No             |                                     | n? (Specify Y<br>Puerto Rican, | es or No-<br>, etc.)                     | 14. Race - An<br>Black, Wh<br>Specify: W | iite, etc.  |
| Maryland 21215-0036 | I within<br>liene.<br>r then "  | Completed        | 15. Decedent's<br>(Specify only highest<br>Elementary/Secondary (0-12)<br>10   |   | (Give   | dent's Usual Occu<br>kind of work done<br>DO NOT use retire<br>naker | during most o                       | of working                     |  | Kind of Busines                          | ·   |
| ryland              | should be filed and Mental Hygie<br>marked other<br>umatic event, II  | To Be C          | 17. Father's Name (First, Middle, La<br>Vincent Piazza<br>19a. Informant's Name/Relationshi  |   | 406-44-35   |  | Vene                                | ra Val                         |  |  |   |
| Baltimore, Ma       | es 1 and 2<br>of Health a<br>f item 27 is<br>r other treu   |                  | Elizabeth V. Coo   | olahan/Daug   | ghter 3013<br>20b. Place of Disponsion                                    | matory or other pla  | Lane,                               | Ellico<br>Date                 | tt City                                  | , MD 21                                  | 042   |
| Baltii              | p-rmit. Page<br>Department:<br>Importent: flangoriant any injury o  |                  | 21. Signature of Funeral Service Li  | censes Oals   | xoske V   | Name and Addr<br>Vitzke Fu<br>1630 Edmo                              | ess of Facility<br>ineral<br>omdson | Home o<br>Ave C                | f Caton<br>atonsvi                       | sville,                                  | Inc.<br>21228                                     |
|                     | Pnysician<br>/Medical   |                  | 23a. Part1. Enter the disease, or c<br>shock, or heart failure. List or<br>Immediate Cause (Final<br>disease or condition<br>resulting in death)           | nly one cause on each   | sed the death. Do not entrolled in line. $6EST(VE)$ as a consequence of): | HEART  | -                                   |                                |  |  | Approximate interval Between Onset and Death      |
| 8760,               | death centificate be executed by eattending physician and id for use as the burial-transit  | dical Examiner   | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | Due to (or a  | as a consequence of):   | OKTIC  | 576                                 | EN 051                         | \$                                       |  | 6 months  |
| O. Box 6            | at the death certific<br>by the attending p<br>tached for use as i  | Physician/Med    | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown  |   | 2 Fetal death 3 at time of death 5  | Ectopic pregnanc<br>Other (specify)                                  | у                                   |                                |  | 23d. Date of d<br>Month                  | elivery<br>Day Year                               |
| ords, P.            | w requires that the<br>been signed by th<br>should be detache   | by               | Part II. Other significant condition   | s contributing to death   | but not resulting in the u  | nderlying cause gr   | ven in Part I.                      | 2:                             |  |  | to the cause of death?  Probably 4 □Unknown       |
| Vital Record        | The taw<br>ate has b<br>page 2 st   | e Completed      | 25. Was case referred to medical   |   |   |  | OS Plane                            |                                | 4a. Was an autopsy performed?  Yes 2x1No | prior to<br>death?                       | autopsy findings available completion of cause of |
| Ž.                  | Physicien:<br>this certific<br>al director,   | 0 8              | examiner?<br>1 ☐ Yes 2 ☑ No  | Hospital:   | ttient 2 ☐ ER/Outpatier   | nt 3 DOA Ot  |                                     |                                | Residence                                | 6 ☐Other (Sp                             | ecify)  |
| Division of         | ending<br>eath.<br>or: After<br>he funer  | Certification; T | 27. Manner of Death  1 Natural 2 Accident 3 Suicide 6 Could no   | tion  | Day Year) Injury  | f 28c. Inju<br>Wa  | ry at                               | 28d. D                         | escribe how inju                         | iry occurred                             |   |
| Divi                | • Hospitel or Attend<br>24 hours after death<br>• Funeret Director: ,<br>etely filled in by the f   |                  | 4 Homicide determin  | building,   | Injury - At home, larm, streetc. (Specify)  st of my knowledge, deat      |  | me date and                         | Ci                             | ty or Town, Stat                         | e)                                       | Rural Route Number,                               |
|                     | To the Hos<br>within 24 h<br>To the Fun<br>completely   | Medical          |  | xaminer: On the basis<br>and manner   | of examination and/or in  | vestigation, in my   | opinion, death                      | occurred at the                | he time, date an                         | d place, and du                          | e to the cause(s)                                 |
| ì                   | D   |                  | 30. Name and address of person w   | ho completed cause o  | MD<br>f death (Item 23a) (Type,   | N 4 6  | 300                                 |                                | 12,                                      | 126/                                     | 21044   |
| l                   | Sta   |                  | ROBERT E.  31. Date filed (Month, Day, Year)  DEC 2 8  | MCCANTA   | y 1070<br>strar's Signature   | O CHART  | en bn                               | IVE C                          | OLUMBI                                   | A MID                                    | 21044   |
|                     | Registr   | ar               | UEU 4 0  | 5007  | the so be   |  |                                     |                                |  |  |   |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Regi**Afficend Item #18 Per FH G850 12/30/05 JH** Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Dec  $23^{\text{Day}}$ **Physician** 2005 7:20 August Buschman Ам /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Winfield
If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Senior Constant Care Carroll 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1X M 2□ F Yrs. Director July 29, 1918 216-01-2413 Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or itams 23a or 28a-f show the Medical Examiner must be notified at 1 Yes 2 No Md Carroll Eldersburg by Funeral Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 2025 Conan Doyle Way 21784 US 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify White 3 X Widowed 4 ☐ Divorced "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. Is marked other then College (1-4or 5+) Etementary/Secondary (0-12) Welder Machinery 12 other traumatic event, 18. Mother's Name (First, Middle, Maiden Sumame)
HIIda Wagner
HIIda 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be Bernard Buschman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If Item 27 is any injury or other trains once. 2025 Conat Doyle Way, Eldersburg,

20b. Place of Disposition (Name of cometery, crematory or other place)

20c. Locat Henry Buschman son MD 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Crest Lawn Mem Gardens Dec 27 2005 Marriottsville, MD \* 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Burrier-Queen Funeral Home & Crematory 21. Signature of Funeral Service Lices 23a. Parn. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** minutes disease or condition resulting in death) /Medical Due to (or as a consequence of Examiner minutes Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Physiclan/Medical Examiner burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760. use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death 5 Other (specify) page 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by Division of Vital Records, mellitus 1 Yes 3 Probably 4 Unknown 2 No Failure Rena 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 1 🗌 Yes 2 🗆 No funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Certification: To this 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After 1 Natural
2 Accident Injury 5 Pending 1 ☐ Yes 2 ☐ No 24 hours after death. Funeral Director: A investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier within 24 hor To the Fune completely fi (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 23/05 30. Name and address of person who completed cause of death (ttem 23a) (Type, Print) Eldersburg MD 21784

Registrar

Progress Way

32. Segistrar's Signature

1380

M.K. MCEVOY 31. Date filed (Month, Day, Year)

DEC 2 8 2005

Sute 114

|                     |  |                       | 1 - For State Registrar  | State of M  | larylar                     | nd / Depa                               | rtmen<br><i>tificat</i> | t of H                             | ealth a<br>D <i>eath</i>               | ınd M               |   | jiene                   | 005  | 41770                                       |
|---------------------|--|-----------------------|--|---|-----------------------------|---|-------------------------|------------------------------------|--|---------------------|---|-------------------------|--|---|
|                     | Physic   | ian                   | 1. Decedent's Name (First, Middle, Last) Tigist Berku  |   |                             |   |                         |                                    |  |                     | 2. Date of Dea<br>Month                       | th<br>Day               | Year   | 3. Time of Death                            |
| )                   | /Medi<br>Examir  |                       | 4a. Facility Name (If not institution, give s 7710 Maple View  |   | )                           |   | ,                       |                                    | Location of                            |                     | 12  |                         | 2005<br>ounty of Death<br>Montgom                          |   |
|                     | Funeral<br>Director  |                       | 5. Social Security Number 6. Sex 220-55-9958   |   | ge (In yrs.<br>26           | last birthday)<br>Yrs.                  |                         | 1 Year<br>Days                     |  |                     | 8. Date of Birth<br>(Month, Day<br>09-05-     | Year)                   | 9. Birth   | place (State or Foreign<br>ntry)            |
|                     | th the Maryland<br>or 28a-f ehow   | Irector               | Usual Residence of Decedent   10a. State   |   |                             | y, Town or Loakoma                      |                         | ) Code                             |  |                     | 1   | 0g. Citize              | n of What Cou  | 10d. Inside City Limits 1 XYes 2 □ No ntry? |
| 9036                | 2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "nature!", or items 23s or 28s-f show surnatic event, the Marikal Examitiar must be notilised as  | d by Funeral Director | 12©Never Married 2 Marned<br>3 Widowed 4 Divorced  | 2. Was Decedent<br>Armed Forces<br>1 ☐ Yes 25<br>If Yes, Give<br>Year or Dates: | ?                           |   | Vas Deced<br>Yes, spec  | dent of His<br>cify Cubar          | spanic Orig<br>n, Mexican,<br>Specify: |                     | cify Yes or No-<br>Rican, etc.)               | 14                      | niopia Race - Ameri<br>Black, White,                       | etc.  |
| Maryland 21215-0036 | iled within 72 h<br>tygiene.<br>her than "nati<br>nt, the Medica   | Completed             | 15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12) 12   |   | 5+)                         | life. L                                 | kind of wo<br>OO NOT u  | rk done de<br>se retired)<br>At te | enden                                  | t                   |   | Pı                      | of Business/Ir   |   |
| rylanc              | should be find Mental Hearth and Mental Hearth of umarked of umarked of  | To Be                 | Berku Beyen  19a. Informant's Name/Relationship (Ty)   | ne Print)   |                             | 19h Mailin                              | a Address               |                                    | Ze                                     | rfe.                | (First, Middle, I<br>Argaw<br>                |                         |  | Code  |
|                     | 1 and<br>Health<br>em 27<br>ther tr  |                       | Zerfe Argaw/mothe  | er  | 1 6                         |   | Map                     | le Vi                              | iew A                                  | ve.                 | Takoma :                                      | Park                    |  | 12  |
| Baltimore,          | permit. Pages<br>Department of<br>Importent: If it<br>eny injury or o  |                       | 1 反 Burial 2 ☐ Cremation 3 ☐ R. 4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Funeral Service License   |   | 1 _                         | orge Wa                                 | shing<br>Name an        | gton<br>d Address                  | Cem s of Facility                      | ,                   | 29-2005                                       |                         | lphia,   | MD  |
| n                   | 88 = 8   |                       | 23a. Part1. Enter the disease, or complishock, or heart failure. List only on  | ations that cause   | d the deat                  |   | 933                     | Gist                               | Av                                     | Silv.               | remation<br>er Sprin<br>respiratory are       | ng MI                   | vice<br>20910  | Approximate<br>Interval Between             |
| 8/60,               | death certificate be executed  Madical | dical Examiner        | Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, fary leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | Due to (or as   | a conseq                    | uanca of):                              | Carci                   | noma                               |  |                     |   |                         |  | Onset and Death                             |
| O. Box 6            | ath certif<br>ittending<br>or use a  | Physician/Me          | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2□No 9 □ Unknown  | Sc. If yes, outcome 1 Live birth 4 Pregnant a 9 Unknown                         | 2 Feta                      | Ideath 3                                | Ectopic pr<br>Other (sp |                                    |  |                     |   | 236                     | d. Date of delive<br>Month                                 | ery<br>Day Year                             |
| cords, P            | w requires that the de<br>been signed by the a<br>should be detached f   | ۵                     | Part II. Other significant conditions con  | ributing to death t   | out not res                 | ulting in the un                        | derlying c              | ause giver                         | n in Part I.                           |                     |   | acco use                |  | ne cause of death?                          |
| He                  | The law<br>ite has b<br>age 2 sl   | Completed             |  |   |                             |   |                         |                                    |  |                     | 24a. Was ar<br>autops<br>perform<br>1 Yes 2   | y                       | 24b. Were auto<br>prior to co<br>death?<br>1 \( \text{Yes} | psy findings available mpletion of cause of |
| 5                   | ding Phys<br>n.<br>After this<br>funeral di  | atlon: To Be          | 25. Was case referred to medical examiner? 1  Yes 2 No  27. Manner of Death 1 Natural 5 Pending 2 Accident investigation   | ospital:<br>1  Inpati<br>28a. Date of Inju<br>(Month, Da                        |                             | ER/Outpatient<br>28b. Time of<br>Injury |                         | 8c. Injury                         | 4 🗆 Nurs                               | sing Hom            | Check only only only only only only only only | nce 6                   |  | y)  |
| DIVISION            | To the Hospital or Attence within 24 hours after death To the Funeral Director: completely filled in by the  | Certification:        | 3 Suicide 6 Could not be<br>4 Homicide determined  | 28e. Place of In<br>building, e   | jury - At ho<br>c. (Specify | ome, farm, stre                         | et, factory             | , office                           |  | 2                   | 8f. Location (St.<br>City or Town             | eet and N<br>, State)   | lumber or Rura   | l Route Number,                             |
|                     | To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by   | ledical               | 29a. Certifier 1 Certifying Phys (Check only one) 1 Medical Examin   | cian: To the best<br>er: On the basis of<br>and manner st                       | f examina                   | wledge, death<br>tion and/or inv        | estigation,             | in my opi                          | nion, death                            | place, a<br>occurre | nd due to the ca<br>d at the time, da         | use(s) an<br>ite and pl | d manner as stace, and due to                              | lated.<br>the cause(s)                      |
| )<br>i              | S COT  | W                     | 29b. Signature and tiple of certifier  |   |                             |   |                         | D52                                |  |                     | 25  |                         | igned <i>(Month,</i><br>26-2005                            |   |
| 4                   | *  |                       | 30. Name and addr of pe who cor<br>Harminder S. Seth<br>31. Date filed (Month, Day, Year)  | i MD 140  | 0 For                       |   |                         | e 43                               | 5 S <b>i</b> 1                         | ver                 | Spring  | MD 2                    | 0910   |   |
|                     | Sta<br>Registr   | -                     | DEC 2 8 20   | 05 32. Hugisti  | ars Signa                   | A. A.                                   | SO VIE                  |                                    |  |                     |   |                         |  |   |

|                            |   |                   | 4 (0)   | artment of Health and Mental Hy rtificate of Death   | giene 005 41771  |
|----------------------------|---|-------------------|---|--|--|
| try                        | Physici<br>/Medic   |                   | Decedent's Name (First, Middle, Last)     Emma M Blazek   | 2. Date of Di<br>Month<br>December   | page 10:35 P M   |
|                            | Examin  |                   | 4a. Facility Name (If not institution, give street and number)  | 4b. City, Town, or Location of Death   | 4c. County of Death  |
|                            |   |                   | Manor Care Rossville  | Baltimore County  If Under 1 Year   If Under 24 Hrs.   8 Date of Bi  | Baltimore  |
| .00                        | Funeral:<br>Director  |                   | 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, 1 M 2 T 87 Yrs.   | Months Days Hours Min (Month D   | orth (2) 9. Birthplace (State or Foreign Country)  Y 12 1918 Middle River, M.                                |
|                            | D   |                   | Usual Residence of Decedent   |  | y 12 1919 Fildrie River, Fil.  |
|                            | arylar<br>ehow  | _                 | 10a. State 10b. County 10c. City, Yown or L   |  | 10d. Inside City Limits  |
|                            | the M   | Directo           | Maryland Baltimore White Mar  | CSh<br>10f. Zip Code   | 1 ☐ Yes 2 ☐ No  10g. Citizen of What Country?  |
|                            | with Sa or  |                   | 5804 Carrington Drive   | 21162  | USA  |
|                            | ms 2;   | Funeral           |   | Was Decedent of Hispanic Origin? (Specify Yes or No<br>If Yes, specify Cuban, Mexican, Puerto Rican, etc.)     |  |
| 36                         | vithin 72 hours after death with the Maryland<br>liene<br>rthen "natural", or Itame 23a or 28e-f ehow<br>the Medical Examinar nual be modified at | by Fur            | Armed Forces?  1 Never Married 2 Married 1 Yes 2 No If Yes, Give  3 Widowed 4 Divorced Year or Dates:   | If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  1 □ Yes 2 ▼No Specify:                                    | Specify:   |
| Maryland 21215-0036        | 72 hound  |                   | 15. Decedent's Education 16a. Dece  | dent's Usual Occupation  | Mhite 16b. Kind of Business/Industry   |
| 218                        | within 7<br>ene.<br>then "n   | Completed         | (Specify only highest grade completed) (Give Elementary/Secondary (0-12) College (1-4or 5+)   | e kind of work done during most of working<br>DO NOT use retired)  |  |
| 121                        |   |                   | 12 N/A Houses   | vife  18. Mother's Name (First, Middle   | Housekeeping-Own Home  |
| and                        | od ital   | o Be              | Charles Fliener   | Marie Norris   | , Maiden Sumame)   |
| ary                        | å e E E   | 2                 |   | ng Address (Street and Number or Rural Route Numb  | per, City or Town, State, Zip Code)  |
|                            | and 2<br>salth a<br>n 27 le   |                   | Carl E Blazek (Son) 403 A   | rora Drive Millersville, Mary  | vland 21108 1909   |
| ore                        |   |                   | 20a. Method of Disposition 1 ☐ Burial 2 【X Cremation 3 ☐ Removal from State 20b. Place of Disposition 20b. Place Obs. Place of Disposition 20b. Place Obs. P | osition (Name of Date matory or other place)   | 20c. Location - City or Town, State  |
| Baltimore,                 | tment<br>tant:<br>tant:   |                   | 4 Donation 5 Other (Specify) Metro Cre  | natory Inc December 27 2005  | Baltimore, Maryland  |
| Bal                        | permit. Page<br>Department of<br>Important: If<br>any injury or   |                   | Mother Annie Cart   | 2. Name and Address of Facility  Cassahn Funeral Home  7/01 Relair Pood Baltings Muss                          | Jan 21236  |
|                            |   |                   | 23a. Part1. Enter the disease, or complications that daused the death. Do not en shock, or heart failure. List only one cause on each line.   |  |  |
|                            | Physician /Medical  |                   | Immediate Cause (Final disease or condition resulting in death)   | -c Carcinal  |  |
| 100                        | Examiner  |                   | Due to (or as a consequence of):  | ourie  | o years  |
|                            | *   | ner               | Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury   |  | 8  |
|                            | ocuted<br>nd<br>transit   | Examir            | that initiated events C.  |  |  |
| 90,                        | ate be executed<br>hysicien and<br>the burial-transit   | EX                | resulting in death) Last Due to (or as a consequence of):   |  |  |
| 68760,                     | physicate t   | dica              | d   |  |  |
| Box (                      | death certificate be executed<br>e attending physicien and<br>of for use as the burial-transit  | Physician/Medical | #I the past 12 monitor:   | □Ectopic pregnancy □ Other (specify)   | 23d. Date of delivery  Month Day Year  |
| P.O.                       | that the de<br>ed by the<br>detached  | nysic             | 1 Li Yes 2 No 9 Unknown 9 Unknown   | Journal (specify)  |  |
|                            | es<br>ign<br>be   | by                | Part II. Dther significant conditions contributing to death but not resulting in the teachers.  | underlying cause given in Part I. 23e. Did   | tobacco use contribute to the cause of death?  Yes 2 □ No 3 □ Probably 4 □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ |
| Soci                       | requir<br>been s<br>should  | etec              | d   | 'sene  |  |
| Division of Vital Records, | e lav   | Completed         |   |  | psy prior to completion of cause of death?   |
| ital                       | ysician: Th<br>is certificate<br>director, pag  | BeC               | 25. Was case referred to medical examiner?  | 1 ☐ Yes<br>26. Place of Death (Check only  |  |
| ) t                        | d is  | ဥ                 | 1 ☐ Yes 2 ☑ MO Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatie  |  | dence 6 ☐ Other (Specify)  |
| uc                         | Attending Physician: r death. ector: After this certifici<br>by the funeral director, i   | tlon:             | 27. Manner of Death  1. ■ Natural 5 □ Pending (Month, Day Year)  28b. Time of Injury  | of 28c. Injury at Work?  M 1 ☐ Yes 2 ☐ No 28d. Describe  | how injury occurred  |
| isi                        | after death<br>Director:<br>in by the   | ficat             | 2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury. At home, larm, st  |  | Street and Number or Rural Route Number.   |
| Ö                          | s after<br>s after<br>el Dire   | Certification:    | 4 ☐ Homicide determined building, etc. (Specify)  | City or To   |  |
|                            | To the Hospital or Attending Ph<br>within 24 hours after death.<br>To the Funarel Director: After th<br>completely filled in by the funeral       | edical (          | 29a. Certifier (Check only one)  1 Certifying Physicien: To the best of my knowledge, deal control on the basis of examination and/or in and manner stated.   | h occurred at the time, date and place, and due to the vestigation, in my opinion, death occurred at the time, | cause(s) and manner as stated. date and place, and due to the cause(s)                                       |
|                            | To the within 2 To the complet  | Me                | 29b. Signature and title of certifier   | 29c. License number  | 29d. Date signed (Month, Day, Year)  |
|                            | 0   |                   | Millon'cid  | D00083(8   | VEC 26 2001  |
| 6                          | )   |                   | 29b. Signature and title of certifier  30. Name and address of person who completed cause of death (Item 23a) (Type,  21. Date filed (Month, Day, Year)  31. Date filed (Month, Day, Year)  22. 2005  | Print) 8903 HARF BALT: 190RF   | MARYLANIX  |
|                            | Sta<br>Registr  | te<br>ar          | 31. Date filed (Month, Day, Year) DEC 2 8 2005  Registrar's Signature   | we   | 2/234  |

|  | •              |  | Department of l  | Health and M                                  | ental Hygie                                       | ne<br>2005                               | 11772  |
|--|----------------|--|--|---|---|--|--|
|  |                | Hegistrar  1. Decedent's Name (First, Middle, Last)  | Oortmeate or   | Death   | Reg.<br>2. Date of Death                          | Ne. O O O                                | 3. Time of Death                                   |
| Physicia   |                | Kathleen Bland   |  |   | Month 12  | Day Year 2005                            | 10:50 AM   |
| /Medica  |                | 4a. Facility Name (If not institution, give street and number)   | 4b. City. Town.  | or Location of Death                          | 10 0  | 4c. County of Dea                        | 10.00  |
| Examine  | er<br>T        | Franklin Square Hospital (   | Enter Bose   | dale  |   | Baltim                                   |  |
| Funeral  |                | 5. Social Security Number 6. Sex 7. Age (In yrs. Ia  |  | r If Under 24 Hrs.                            | 8. Date of Birth                                  | 9. Bir                                   | indiace (State or Foreign                          |
| Director   |                | 212- 42-4557 10M 2MF   | 2 Yrs. Months Days   | Hours Min.                                    | 8. Date of Birth<br>Month, Day, Ye<br>Jeptember 3 | 1943 Pen                                 | nsylvania  |
| 5  |                | Usual Residence of Decedent  |  |   |   |  |  |
| show   | _              |  | , Town or Location   |   |   |  | 10d. Inside City Limits                            |
| 88-1   | cto            | Maryland Balhmore  | Essex  |   |   |  | 1.  Yes 2 No                                       |
| (PEN) 1215-0036 within 72 hours after death with the Maryland ene. than "retural", or items 23a or 28a-1 show the Mardical Example of the mailified at   | al Director    | 10e. Street and Number  Lo EVA Ct.   | 10f. Zip Code  | 21220   | -   | Citizen of What Co                       | states   |
| dea  | Funeral        | 11. Marital Status 12. Was Decedent Ever in U.S Armed Forces?  | 6. 13. Was Decedent of<br>If Yes, specify Cub                                    | Hispanic Origin? (Spe                         | cify Yes or No-                                   | 14. Race - Ame                           |  |
| after or ite   | 리              | 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☑ No   | 1 ☐ Yes 2 ☑ No   |   | ricari, etc.)                                     | Black, Whit                              | e, etc.  |
| 21215-0036 d within 72 hours att giene. The Madrell Control of the M | d by           | 3 ☐ Widowed 4 ☐ Divorced Year or Dates:  | - 10163 20110  | э оросну.                                     |   | Specify: LL                              | nite   |
| 72 T 27  | Completed      | 15. Decedent's Education (Specify only highest grade completed)  | 16a. Decedent's Usual Occu<br>(Give kind of work done<br>life. DO NOT use retire | upation<br>e during most of workii            | 16b   | b. Kind of Business                      | Industry   |
| 12.12.12.13.13.13.13.13.13.13.13.13.13.13.13.13.   | du.            | Elementary/Secondary (0-12) College (1-4or 5+)   | IT & Computer  |   | ooter Ba  | Ihmore Lif                               | e Insurance  |
| d 2 d 2 Higher Hygie other the   |                | 17. Father's Name (First, Middle, Last)  | TI . Compace.  | 1   | (First, Middle, Maid                              |  |  |
| Katanarylance should be to marked o umatic eve   | To Be          | Eugene Callahan  |  | Betty   |   | thover                                   |  |
| Md 2 lift a 27 lift a 27 lift a  |                | 19a. Informant's Name/Relationship (Type, Print)<br>Stephen Kay Wood (Son)   | 19b. Mailing Address (Stree  | ESS≥x, MD.                                    | I Route Number, Ci<br>21220                       | ty or Town, State, 2                     | Zip Code)  |
| S 1 a s 1 a othe   |                |  | ace of Disposition (Name of<br>metery, crematory or other pla                    |   |   | . Location - City or                     | Town, State  |
| mor imor   |                |  | VIEW Cremato   | The contra                                    | 105   | Baltimore,                               | Maryland   |
| Baltimore, Baltimore, permit. Pages 1 ar Department of thea Important: If item: any injury or other  | - 1            | 21. Signam e of Funeral Service Licensee   | 22. Name and Addre   | ess of Facility                               | ( -   | ndalk, P.                                |  |
| Bal Bal Bal Bal Bal Bal Bal Bal Bal Bal  |                | V  | Connelly 7   | Funeral Hom<br>Hers Pt. E.                    | 1. Dynda  | ,  | 21222  |
| 176(<br>Ite be<br>sysicia<br>ne bur  | ilcal Examiner | 23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of the cons | ry fallure<br>enoton:<br>e alloblasto<br>ence an:                                | omo.  |   | V  | Approximate<br>Interval Between<br>Onset and Death |
| P.O. Box 68760, that the death certificate be end by the attending physician detached for use as the burian  | Physician/Med  | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown  23c. If yes, outcome of pregnant 1 ☐ Live birth 2 ☐ Feal of 4 ☐ Pregnant at time of deal 9 ☐ Unknown  | death 3 Ectopic pregnance  | су  |   | 23d. Date of del<br>Month                | ivery<br>Day Year                                  |
| ds, P. (ires that the signed by die detace   | ρ<br>λ         | Part II. Other significant conditions contributing to death but not result   | ting in the underlying cause gr  | iven in Part I.                               |   |  | the cause of death?                                |
| Cord W requir  | ted            | Seizure  |  |   | I ☐ Yes   | 2 120 NO 3   Pr                          | obably 4 Unknown                                   |
| Division of Vital Records, I or Attending Physician: The law requires ta after death. Director: After this certificate has been signed in by the funeral director, page 2 should be a  | Completed      | Confusion  |  |   | 24a. Was an autopsy performed                     | prior to death?                          | topsy findings available<br>completion of cause of |
| f Vital Reysteian: The Iss certificate had director, page  | a              | 25. Was case referred to medical   |  | 26. Place of Death                            | (Check only one)                                  | No I Tes                                 | 2□ No  |
| ysici,   | 0              | examiner?  | R/Outpatient 3 DOA Ott   |   | ne 5 Residence                                    | 6 DOther (Sper                           | rifu)  |
| on of ding Phys  | u.             | 27. Manner of Death 28a. Date of Injury 2  | 28b. Time of 28c. Inju   |   | 8d. Describe how in                               |  | niy)   |
| ion (nding Fath.   | atlo           | 1 SNatural 5 Pending (Month, Day Year) 2 Accident investigation  |  | yes 2 □ No                                    |   |  |  |
| Division or Attendate death Director: in by the  | Certification  | 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At hom building etc. (Specify)   | ne, farm, street, factory, office  | 2   | 8f. Location (Street                              |  | ral Route Number,                                  |
| Di al or safte   | e              | building, etc. (Specify)   |  |   | City or Town, St                                  | are)                                     |  |
|  | Medical        | 29a. Certifier (Check only one)  1★ Certifying Physicien: To the best of my know and manner stated.  | ledge, death occurred at the tion and/or investigation, in my                    | ime, date and place, a opinion, death occurre | nd due to the cause<br>od at the time, date       | e(s) and manner as<br>and place, and due | stated.<br>to the cause(s)                         |
| To the vithin compl  | Me             | 29b. Signature and title of certifier  | 29c. Licens  | se number                                     | 29d.  | Date signed (Month                       | 7, Day, Year)                                      |
|  |                | 1/1/1/ to mi   | Rosa   | mac   | 1   | 2/2/2/1                                  | 5  |
|  | +              | 30. Name and address of person who completed cause of death (Item 2  | 23a) (Type, Print)   | 0000  |   | 7-410                                    |  |
| 10   |                | RANIANA MITTA, MD 9000 F   | ranklin Saua   | re Drive                                      | Baltimin  | re Mil :                                 | 21237  |
| State  |                | 31. Date filed (Month, Day, Year) 22. Registrar's Signatu  | beeks  |   |   | 10, 1510.0                               | 10101  |
| Registra   | r              | DEC 2 8 2005   | March  |   |   |  |  |

|            |  |                   | Unpend Amend item#<br>1 - For<br>Registrar   | State of Ma  |   | artment of F<br><i>rtificate of</i>         |  |   | giene<br>Reg. No.                       | 5 41773   |
|------------|--|-------------------|--|--|---|---|--|---|---|---|
|            |  |                   | 1. Decedent's Name (First, Middle, Last  | Anti IIIA  | ard Burriss,  | Jr.   |  | 2. Date of Dea                            | ath                                     | 3. Time of Death  |
|            | Physici<br>/Medio  |                   | <del>-</del>   | oseph Ho   | ward Burri  | <del>s, Jr.</del>                           |  | Decembe                                   |   | 05 2:25 A M   |
|            | Examir   | er                | 4a. Facility Name (If not institution, give  |  |   |   | r Location of Death                        | 1   | 4c. County of                           |   |
|            |  |                   | Carroll Hospital  5. Social Security Number 6. Se  |  | (In yrs. last birthday)                                 | Westmi                                      | nster If Under 24 Hrs.                     | 8. Date of Birt                           | Carrol                                  |   |
|            | Funeral Director   |                   |  | (M 2□F   | 46 Yrs.   | Months Days                                 | Hours Min.                                 | (Month, Day                               | y, Year)                                | Birthplace (State or Foreign Country)                           |
|            | D.   |                   | Usual Residence of Decedent  |  |   |   |  | August                                    | 15, 1959                                | Maryland  |
|            | arylar<br>ehow   | _                 | 10a. State 10b. County   |  | 10c. City, Town or Lo                                   | cation                                      |  |   |   | 10d. Inside City Limits 1 ☐ Yes 2 ☐ No                          |
|            | The M  | Director          | Maryland H  10e. Street and Number   | oward  |   | 104 7i- Code                                | Columbia                                   |   | 10- 011                                 |   |
|            | 72 hours after death with the Maryland<br>*naturel*, or Items 23e or 28e-f ehow<br>edical Exartl, er must be ricitified at   |                   |  |  |   | 10f. Zip Code                               | 21045                                      |   | 10g. Citizen of Wh                      |   |
|            | death<br>ms 23   | Funeral           | 8740 Tamar Dr.   | 12. Was Decedent E   | ver in U.S.   13. \                                     | Was Decedent of H                           | lispanic Origin? (Si<br>an, Mexican, Puert | pecify Yes or No-                         | 14. Race -                              | U.S.A.  American Indian,  |
| ٥          | or ite   | 교                 | 1 Never Married 2 Married  | Armed Forces?  1 Yes 2 N  If Yes, Give.                                | 0   1   |   |  | o Rican, etc.)                            | White, etc.                             |   |
| 3          | urel',   | d by              | 3 ☐ Widowed 4 ☑ Divorced   | Year or Dates:   |   | 1 ☐ Yes 2/△ No                              | Specify:                                   |   | Specify:                                | White   |
| ဂ်         | 72   | Completed         | 15. Decedent's Edu<br>(Specify only highest grad   | ication<br>le completed)   | (Give   | lent's Usual Occup<br>kind of work done     | during most of wor                         | king                                      | 16b. Kind of Busi                       | ness/Industry   |
| Z          | within<br>then<br>then   | ם                 | Elementary/Secondary (0-12)  | Colfege (1-4or 5-  | +)  | DO NOT use retired<br>Tra                   | e Removal                                  |   |   | Landscaping   |
| ס<br>ס     | H T T  | 0                 | 17. Father's Name (First, Middle, Last)  |  |   | - 110                                       |  | ne (First, Middle,                        | Maiden Sumame)                          |   |
|            | 2  | To B              | Joseph H   | oward Buriss   |   |   |  | Shirle                                    | y Elaine Size                           | emore   |
| ary        | and and  |                   | 19a. Informant's Name/Relationship (7)   | rpe, Print)  | 19b. Mailin   | g Address (Street                           | and Number or Ru                           |   | r, City or Town, St                     |   |
|            | s 1 and 3<br>f Heelth<br>Item 27<br>other tra  |                   | Ms. Jean P. Cofiell  | Siste  |   |   | Dr. Columbia                               |   |   |   |
| Baltimore, | Pages 1<br>Tent of H<br>int: If Ite<br>iry or otl  |                   | 20a. Method of Disposition 1 ☐ Burial 2 DC Cremation 3 ☐ F   |  | 20b. Place of Dispo<br>cemetery, cren                   | sition (Name of<br>natory or other plac     | (e)  | Date                                      | 20c. Location - Ci                      | ity or Town, State  |
|            | P P F P  | 1                 | 4 Donalion 5 Other (Specify) 21. Sonature of Fundral Service Lines                                       | ,  | Bay   | view Cremat                                 | LH V                                       | 2/23/2005                                 | В                                       | altimore, MD  |
| Ba         | permit. Departmimports Imports eny Inju  |                   | 21. Sonature of Fundral Service Lieus  | ne mo  |   | . Name and Addre                            | Funeral Hon                                | ne P A                                    |   |   |
| <u></u>    | Physician<br>/Medical<br>Examiner  | ıer               | ii any, leading to immediate   | a Staphylococ  Due to (or as a   | e.  CLIS ALITELIS SE I consequence of):                 |   |  |   |   | Approximate<br>Interval Between<br>Onset and Death              |
|            | deeth certiticate be executed<br>e attending physicien and<br>id for use as the burial-transit                               | fedical Examiner  | causé. Enter Undertying<br>Cause (Disease or injury<br>that initiated events<br>resulting in death) Last | Due to (or as a  | consequence of):  |   |  |   |   |   |
| ָ          | iche th  | Physician/Medical | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown                  | 23c. ff yes, outcome of 1 □ Live birth 2 4 □ Pregnant at t 9 □ Unknown | 2 ☐ Fetal death 3 ☐                                     | Ectopic pregnancy<br>Other (specify)        |  |   | 23d. Date of Month                      | ,   |
| <u>v</u>   | Se Co  | by F              | Part II. Other significant conditions co   | -  |   |   |  |   | ^                                       | ute to the cause of death?                                      |
| 20         | w require<br>been si<br>should I   | sted              | Cardiomegaly with nod  | an ansease, o  | curonic narco   | olisin; obes                                | ıcy  | 1 D Y                                     | es 2 2 No 3                             | Probably 4 Unknown  |
|            | The la   | Completed by      |  |  |   |   |  | 24a. Was a autop: perfor                  | sy prio<br>med? dea<br>2 □ No 1 □       | re autopsy findings available or to completion of cause of ath? |
| Vitai      | Physicien:<br>rthis certifical<br>ral director, p  | o Be              | 25. Was case referred to medical examiner?  1 ☑ Yes 2 ☐ No   | fospital:  | nt 2 ER/Outpatien                                       | t 3 DOA Oth                                 | er. 4 Nursing H                            | 1   | ne)<br>ence 6 □Other                    | (0  |
| 5          | g Phys<br>erthis<br>eral di  | n: 70             | 27. Manner of Death  | 28a. Date of Injury<br>(Month, Day                                     | 28b. Time of  | 28c. Injur                                  |  |   | ow injury occurred                      |   |
|            | Attending<br>r death.<br>octor: After<br>by the fune   | atio              | 1 Natural 5 Pending 2 Accident investigation   | (Month, Day  | Year) Injury  |   | Yes 2□No                                   |   |   |   |
| DIVISION   | tel or Attend<br>is after death<br>el Director: /<br>ed in by the f  | Certification;    | 3 Suicide 6 Could not be<br>4 Homicide determined  | 28e. Pface of Inju-<br>building, etc.                                  | ry - At home, farm, stre<br>(Specify)                   | eet, factory, office                        |  | 28f. Location (S<br>City or Town          |   | or Rural Route Number,  |
|            | To the Hoepitel or Attanding I within 24 hours after death. To the Funerel Director: After completely filled in by the funer | Medical           | 29a. Certifier 1 ☐ Certifying Phy (Check only one) 1 ☐ Medical Exami                                     | sician: To the best of<br>ner: On the basis of<br>and manner stat      | f my knowledge, death<br>examination and/or inv<br>led. | occurred at the tir<br>restigation, in my o | ne, date and place,<br>pinion, death occur | , and due to the c<br>rred at the time, d | ause(s) and mann<br>date and place, and | er as stated.<br>d due to the cause(s)                          |
| :          | vithin 2.  | Σ                 | 29b. Signature and title of certifier  | 1 ~  |   | 29c. Licens                                 | e number                                   | 2   | 29d. Date signed (i                     | Month, Day, Year)   |
|            |  |                   | 1 Jach   | Leep   | Nes   |   | O.C.M.E.                                   | I   | December                                | 17, 2005  |
| )          |  |                   |  |  |   |   |  |   |   |   |
| )          |  |                   | 30. Name and address of person who co  |  | ath (ftem 23a) (Type, I<br>111 Penn S                   |   | .1 + 2                                     | M 1                                       | J 01001                                 |   |

CPM 05-08713 Unpend item#23a,27,28a f,perMf,6852,27/06 II

State of Maryland / Department of Health and Mental Hygiene Pepita Blount 1 - For State Registrar Certificate of Death Reg. No: 2. Date of Death 1. Decedent's Name (First, Middle, Last) December 24, 2005 **Physician** PEPTTA BLOUNT 01:50 /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Johns Hopkins Hospital Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours SOUTH CAROLINA 201-46-8124 1 □ M 2 🗙 F 51 Yrs. NOV 8. 1954 Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show the Medical Examiner must be notified at 1 Yes 2 □ No BALTIMORE MARYLAND NA Director 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? ò 21225 USA 238 845 PONTIAC AVENUE Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: AFRICAN 6 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced "naturel", AMERICAN 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) al Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) HOME HOME MAKER 8 other traumatic event, 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be fill iment of Heelth and Mental H tant: If Item 27 is marked ot Be ICILDA BLOUNT MELVIN BLOUNT 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 845 PONTIAC AVENUE BALTIMORE, MARYLAND 21225 MUSTAFA MUHAMMAD HUSBAND 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 

Burial 2 □ Cremation 3 □ Removal from State 5 rtment c DEC 27, 2005 RANDALLSTOWN, MARYLAND KING MEM. PARK CEMETERY 4 ☐ Donation 5 ☐ Other (Specify) permit.
Departr
Importu 22. Name and Address of Facility 21. Signature of Funeral Service Licensee WYLIE FUNERAL HOME P.A. 638 N. GILMOR STREET BALTIMORE, MARYLAND 21217 23a. Part 1. Enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Tranadol and oxycodone intoxication complicating Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician atherosclerotic cardiovascular disease /Medical Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transit Due to (or as a consequence of): Box 68760. Completed by Physician/Medical use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No signed by the attend 3 Ectopic pregnancy Day Year Month 4 Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 Yes 2□ No 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Other 4 Nursing Home 5 Residence 6 Other (Specify) ٩ 1X Yes 2 □ No 1) Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury Fnd (Month, Day Year) 28b. Time of Fnd Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: After 5 Pending investigation 1 Natural efter death. 1 ☐ Yes XX No 12/24/05 1:15 A 2 Accident unk the 6 Could not be determined 3 Suicide To the Hospital or Atte within 24 hours effer de To the Funerel Directo completely filled in by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) **Johns Hopkins Hospital** 4 Homicide Baltimore, MD found in hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

27 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) ush NID O.C.M.E. December 25, 2005

State Registrar lasha

31. Date filed (Month, Day, Year)

DEC 2 8 2005

DHMH 17 Rev 1/2001

111 Penn Street, Baltimore, Maryland 21201

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) areenbern

Mil

Registrar's Signature

Amend item#31, see 32, per DVR, G850, 12/28/05 Interm#51, see 32, per DVR, G850, 12/28/05 Interm#51, see State of Maryland / Department of Health and Mental Hygiege 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month **Physician** DEC. 25 TAYLOR A. BIRCKHEAD 2005 12:05p<sup>™</sup> /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Wood brook BALTIMORE 6 FARVIEW RD If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 10/01/1920 7. Age (In yrs. last birthday) 5. Social Security Number 9. Birthplace (State or Foreign Funeral 6. Sex Days Hours Months MARYLAND 1**⊠**M 2□F 85 184-12-5668 Director Usual Residence of Decedent the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State 28a-f ehow other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director BALTIMORE MDWOODBROOK 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21212 6 FARVIEW RD USA or Iteme 23a Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. permit Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. If Item 27 is marked other than "naturaf", or Itement intry or other traumatic event, the Medical Examinat 1 ☐ Never Married 2 Married 1 Yes 2 If Yes, Give 2 🗆 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: à WHITE 3 ☐ Widowed 4 ☐ Divorced Year or Dates: WATE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 5+ ENGINEER ENGINEER 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be MARY ALBERT LENNOX BIRCKHEAD ဂ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SYLVIA BIRCKHEAD(WIFE) 6 FARVIEW RD BALTO., MD. 21212. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ⊠Burial 2 □ Cremation 3 □ Removal from State GREEN MOUNT 12/28/2005 BALTO. CITY, MD. 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility
HENRY W. JENKINS & SONS CO. 21. Signature of Funeral Service Licenses 16924 YORK RD MONKTON, MD. 23a. Part1. Enter the disease, or complications that caused the death, shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** years /Medical Due to (or as a conseq Examiner Sequentially list conditions, if any, leading to immoviate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine certificate be executed burial-transit Due to (or as a consequence of): Box 68760 Physician/Medical phys use as the IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐Pregnant at time of death 5 Other (specify) the i Division of Vital Records, P.O. 9☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۵ 90 2 No 3 Probably 4 Unknown 1 Yes page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a Was an certificete has autopsy performed 1 Yes 2 No Hospital or Attending Physician: director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Hospital: Other: 4 Nursing Home 5 June Jence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After 1 HNatural Injury 5 Pending death. 1 TYes 2 □ No 2 Accident investigation To the Hospital or Attend within 24 hours after death To the Funeral Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide 29a. Certifier i 🔁 😂 tifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier ddress of person who completed cause of death (Item 23a) (Type, Print) .Charles 670 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

8 2005

|                     |   |                  | 1 - For<br>State<br>Registrar  | State of Ma   |                           | Depa                           | artment of Hertificate of L  | ealth and   | •  |                      | 005   | 41776   |
|---------------------|---|------------------|--|---|---------------------------|--------------------------------|--|---|--|----------------------|---|---|
|                     | Physici<br>/Medio<br>Examin   | al               | 1. Decedent's Name (First, Middle, L. BEVER ) 4a. Facility Name (If not institution, gi  |   |                           | BA                             | 5DEIV - S1<br>4b. City, Town, or                                   |   | 2. Date of De<br>Month<br>Decemb                   | er 2                 | Y Year 2 2005 County of Death                   | 3. Time of Death 20: 45 P M                   |
| 8                   | Funeral<br>Director   |                  |  |   | 9 (In yrs. last b         | oirthday)<br>Yrs.              | Baltum<br>If Under 1 Year<br>Months Days                           |   | 8. Date of Bir                                     | th<br>ay, Year)      | 9. Birth  | place (State or Foreign                       |
|                     | Maryland  | tor              | Usual Residence of Decedent  10a. State 10b. County  Bermuda N/A   |   | 10c. City, To             |                                |  |   |  | .,,,,,,              |   | 10d. Inside City Limits 1 ☐ Yes 2 No          |
|                     | th with the<br>23s or 28  | Funeral Director | 10e. Street and Number 7 Wellington Back   | Road  |                           |                                | 10f. Zip Code<br>GE01  |   |  |                      | izen of What Cou<br>nuda                        | untry?  |
| 980                 | be filed within 72 hours after death with the Maryland tal Hygiene. Id other then "naturel", or Items 23c or 28a-f show event, i'm Medical Ever'il artimatike Indiffed at | þ                | 11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced   | 12. Was Decedent I<br>Armed Forces?<br>1 Yes 2 No<br>If Yes, Give<br>Year or Dates: |                           |                                | Was Decedent of His<br>f Yes, specify Cubar<br>1 ☐ Yes 2 No        | spanic Origin? (S<br>n, Mexican, Puer<br>Specify: | Specify Yes or No<br>to Rican, etc.)               | <b>)</b> -           | 14. Race - Amer<br>Black, White<br>Specify: Bla | , etc.  |
| Maryland 21215-0036 | i within 72 ho<br>piene.<br>r then "natur<br>the Medical  | Completed        | 15. Decedent's E<br>(Specify only highest g<br>Elementary/Secondary (0-12)   | College (1-4or 5  | +)                        | (Give                          | tent's Usual Occupa<br>kind of work done di<br>DO NOT use retired) | urina most of wo                                  | orking   | 16b. K               | ind of Business/Ir                              | ndustry                                       |
| yland 2             |   | To Be C          | 17. Father's Name (First, Middle, Las<br>William Leroy Bas   | den   |                           |                                | ]  | Phyllis   | me (First, Middle<br>Guishard                      | đ                    |   |   |
|                     | 1 and 2 s<br>Health ar<br>em 27 ls<br>ther treu   |                  | 19a. Informant's Name/Relationship Kennedy Smith / h  20a. Method of Disposition   |   | 7                         | Wel                            | ng Address (Street a<br>Lington Ba<br>sition (Name of              | ack Road  |  | eorge                |   | uda GE01                                      |
| Baltimore,          | Pa<br>ner<br>ury  |                  | 1 Burial 2 Cremation 3 ( 4 Donation 5 Other (Spec  | fy)   |                           | Mary                           | sition (Name of natory or other place S Church                     | Cem 12/   | 31/2005  | War                  | wick, Be  | rmuda   |
| Ba                  | permit. Departr Imports any inj   |                  | 23a. Part 1. Enter the disease of conshock, or heart failure. Jist only  | Wehr  | the death. Do             | 40                             | 01 S. Ches   | ster Str  | eet Balt   | timo                 |   | l Homes PA<br>land 21231                      |
|                     | Pnysician<br>/Medical<br>Examiner   |                  | Immediate Cause (Final disease or condition resulting in death)  | a. Rupti  | URE<br>a consequence<br>V | 0 F<br>e of):                  | BASIL  | AR AR   | tery An  |                      | yIsm  | Interval Between<br>Onset and Death           |
| 8760,               | icate be executed physician and sthe burial-transit   | dical Examiner   | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | Due to (or as a Due to (or as a d.  | ,                         | e of):                         | 1201   | •   |  |                      |   |   |
| P.O. Box 6          | death certif<br>e attending<br>d for use a  | Physician/Med    | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown  | 23c. If yes, outcome<br>1 ☐ Live birth<br>4 ☐ Pregnant at<br>9 ☐ Unknown            | 2 Fetal deal              |                                | Ectopic pregnancy Other (specify)                                  |   |  |                      | 23d. Date of deliv<br>Month                     | rery<br>Day Year                              |
|                     | sign<br>d be  | by               | Part II. Other significant conditions  | contributing to death bu  | ut not resulting          | in the u                       | nderlying cause give   | n in Part I.                                      |  | obacco u<br>Yes 2    |   | the cause of death?<br>bably 4 XiUnknown      |
| Vital Records,      | The law<br>ate has b<br>page 2 si   | Completed        |  |   |                           |                                |  |   | 24a. Was<br>auto<br>perfo<br>1 \( \text{Yes}       |                      | prior to co<br>death?                           | opsy findings available ompletion of cause of |
| of                  | di is   | atlon: To Be     | 25. Was case referred to medical examiner?  1 Yes 2 No  27. Manner of Death 1 Valutural 5 Pending investigating  | Hospital: 1 XInpatie 28a. Date of Injur (Month, Day                                 |                           | Outpatien<br>Time of<br>Injury | 28c. Injury<br>Work  | r: 4 Nursing l                                    | ath (Check only of<br>Home 5 Resi<br>28d. Describe | dence                |   | (y)   |
| Division            | in Diffe  | Certification:   | 3 Suicide 6 Could not determined   | building, etc   | c. (Specify)              |                                | eet, factory, office   |   | City or To   | wn, State            | )   | al Route Number,                              |
|                     | To the Hospitel within 24 hours a To the Funerel completely filled  | ledical          | one)   | hysician: To the best of<br>miner: On the basis of<br>and manner sta                | examination a             | ge, death<br>und/or in         | estigation, in my op   | inion, death occ                                  | e, and due to the<br>urred at the time,            | cause(s)<br>date and | and manner as s<br>I place, and due t           | stated.<br>to the cause(s)                    |
| )                   | To To Coom  | M                | 29b. Signature and title of certifier  | Beck, MI  | b                         |                                | 29c. License   | number<br>5-001                                   |  |                      | e signed (Month,                                | Day, Year) 2005                               |
|                     | Y   |                  | 30. Name and address of person who ROBERT A. BEL   |   |                           |                                | Print)   |   |  |                      | MD 21   | 1287  |
|                     | Sta<br>Registi  |                  | 31. Date filed (Month, Day, Year) DEC 2 8 2  | Registra 30. Registra   | ar's Signature            | 600                            | OIFE St.   |   |  | *                    |   |   |

|            |  |                     | For<br>State<br>Registrar   | State of M   | Marylan                         |                                  | artment o                              |                        |                          | and Ment                           |                           | jierje<br>leg. No.       | 05                            | 41777   |
|------------|--|---------------------|---|--|---------------------------------|----------------------------------|--|------------------------|--------------------------|------------------------------------|---------------------------|--------------------------|-------------------------------|---|
| া          | Physicia   |                     | 1. Decedent's Name (First, Middle,  |  |                                 | ·                                |  |                        |                          | M                                  | ate of Dea                | Day                      | Year                          | 3. Time of Death  |
| - E        | /Medic   | al                  | Swarup Bhatnag  4a. Facility Name (If not institution, g  |  | ar)                             |                                  | 4b. City, Tov                          | wn orl                 | ocation o                |                                    | cembe                     | -                        | 2005<br>ounty of Dea          | 2:00 P.M  |
|            | Examin   | er                  | 4a. Facility Name (II not institution, §  |  | 91)                             |                                  | Poton                                  |                        | Location o               | n Death                            |                           |                          | ntgome                        |   |
|            | Funeral  |                     | 5. Social Security Number 6   |  |                                 | last birthday)                   | If Under 1 Y                           |                        | If Under a               | 24 Hrs. B. Da<br>Min. O. (M        | ate of Birth              | )                        | 9 Bir                         | thplace (State or Foreign                               |
|            | Director   |                     | 228-82-9767   | 1 □ M 2 <b>X</b> □ F   | 75                              | Yrs.                             | MONITO D                               | , 5                    | 1100.0                   | Oct                                | onth, Day                 | , 19.                    | 30 In                         | dia   |
|            | land<br>ow   | -                   | Usual Residence of Decedent  10a. State 10b. County   |  | 10c. Cit                        | y, Town or Lo                    | cation                                 |                        |                          |                                    |                           |                          |                               | 10d. Inside City Limits                                 |
|            | Mary   | tor                 | Maryland Montgom  | nery   | Mon                             | tgomer                           | y Vill                                 | age                    |                          |                                    |                           |                          |                               | 1 ☐ Yes 2X No   |
|            | or 284   | Olrec               | 10e. Street and Number  |  |                                 |                                  | 10f. Zip Co                            |                        |                          |                                    |                           | 10g. Citize              | on of What Co                 | ountry?   |
|            | s 23s  | ra                  | 19850 Wheelwrig   |  | at Ever in II                   | 6 12 1                           | _ 1                                    | 386                    | nania Orio               | gin? (Specify V                    |                           |                          | ed Sta                        | tes<br>erican Indian,                                   |
| 36         | 72 hours after death with the Maryland<br>natural; or Items 23s or 28s-f show<br>Jical Examination collised at   | by Funeral Director | 11. Marital Status  1 □ Never Married 2 □ Married  3 □ Widowed 4 ☒ Divorced                                 | 12. Was Decede Armed Force 1                                       | s?<br>No                        |                                  | f Yes, specify                         |                        | Specify:                 | gin? (Specify Y<br>i, Puerto Rican | , etc.)                   |                          | Black, Whi                    |   |
| 00-        | 2 hour   | ted t               | 15. Decedent's  | Education  |                                 |                                  | dent's Usual C                         |                        |                          | t of working                       |                           |                          | d of Business                 |   |
| 121        | within<br>ne.<br>than "  | Completed           | (Specify only highest<br>Elementary/Secondary (0-12)  | College (1-40<br>5+  | or 5+)                          | Teacl                            | kind of work of<br>DO NOT use i<br>ner | retired)               | ring mosi                | t or working                       |                           | Mont<br>Pub              | gomery<br>Lic Sc              | County<br>hools   |
| pu         | be filed v<br>tal Hygie<br>d other i   | Be                  | 17. Father's Name (First, Middle, La  |  |                                 |                                  |  |                        |                          | er's Name (Firs                    |                           |                          |                               |   |
| ryla       | 2 should be f<br>and Mental I<br>is marked of<br>raumatic eve  | ဥ                   | Shri Saran Biha:  |  |                                 | 19b Mailir                       | ng Address (S                          | treet a                |                          | mati Ra<br>er or <i>Rural R</i> ou |                           |                          |                               | Zip Code)   |
| Ma         | s 1 and 2 should<br>f Health and Men<br>item 27 is marke<br>other traumatic  |                     | Mohit Bhatnagar   |  |                                 |                                  |  |                        |                          | ve, Pot                            |                           |                          |                               |   |
| re,        | ss 1 ar  |                     | 20a. Method of Disposition 1 □ Burial 2 X Cremation 3   |  | 20b. F                          | Place of Dispo                   | sition (Name                           | of                     | - 1                      | Date December                      |                           |                          | ation - City or               |   |
| imo        | Page<br>ment (<br>ant: If<br>ury or  |                     | 4 Donation 5 Other (Spe   |  | C                               | remato                           | rium, J                                | Lnc،                   | l l                      | 27, 200                            | )5                        | Bethe                    | esda, l                       | Maryland  |
| Baltimore, | permit. Pages 1 and 2<br>Department of Health a<br>Important: If item 27 li<br>any injury or other tra<br>2002.  |                     | 21. Signature of Funeral Service Li   |  | 1353                            | Бе<br>Ве                         | thesda<br>thesda<br>thesda             | -Ch<br>M               | evy (<br>aryla           | Chase,<br>and 208                  | Inc. 1<br>14-35           | 7557<br>501              | wisco                         | neral Home/<br>onsin Avenue                             |
| 5          |  |                     | 23a. Part 1. Enter the disease, or c<br>shock, or heart failure. List or                                    | omplications that cau<br>nly one cause on eac                      | sed the deat<br>h line.         | h. Do not ent                    | er the mode o                          | of dying               | , such as                | cardiac or resp                    | oiratory ari              | rest,                    |                               | Approximate<br>Interval Between<br>Onset and Death      |
| j.         | Physician<br>/Medical  |                     | Immediate Cause (Final disease or condition resulting in death)   | a. Metast  |                                 |                                  | Melan                                  | oma                    | ı                        |                                    |                           |                          |                               | 7 Years   |
|            | Examiner.  |                     |   | Due to (or   | as a conseq                     | juence ot):                      |  |                        |                          |                                    |                           |                          |                               |   |
|            | n =  | ner                 | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | b. Due to (or  | as a conseq                     | uence of):                       |  |                        |                          |                                    |                           |                          |                               |   |
|            | ecutec<br>and<br>-transi   | Examlne             | Cause (Disease or injury that initiated events resulting in death) Last                                     | C  | as a conseq                     | mance of):                       |  |                        |                          |                                    |                           |                          |                               |   |
| 8760,      | be executed<br>sicien and<br>burial-transil  | Ical E              |   | 200 10 (01   | a3 a consoq                     | juditios ory.                    |  |                        |                          |                                    |                           |                          |                               |   |
| Ö          | ifficate t<br>g physic<br>as the b   | edic                |   | d.   |                                 |                                  |  |                        |                          |                                    |                           |                          |                               |   |
| .O. Box    | The law requires that the death certificate be executed sie has been signed by the ettending physicien and bage 2 should be detached for use as the burial-transit | Physician/Med       | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒No 9 ☐ Unknown                      | 23c. If yes, outcom<br>1 ☐ Live birth<br>4 ☐ Pregnan<br>9 ☐ Unknow | n 2∏Feta<br>tattime of c        | Ideath 3                         | Ectopic pregi<br>Other (speci          |                        |                          |                                    |                           | 23                       | d. Date of de<br>Month        | olivery<br>Day Year                                     |
| <u>α</u>   | s that II  | by Ph               | Part II. Dther significant condition  | s contributing to deat   | h but not res                   | sulting in the u                 | nderlying caus                         | se give                | n in Part I.             | . 2                                | 23e. Did to               | bacco us                 | e contribute t                | o the cause of death?                                   |
| rds        | w requires<br>been sign<br>should be   |                     |   |  |                                 |                                  |  | _                      |                          |                                    | 1 🗆 Y                     | es 2X                    | No 3∏P                        | robably 4 Unknown                                       |
| Records,   | i: The law re<br>icete has be<br>r, page 2 sho   | Completed           |   |  |                                 |                                  |  |                        |                          |                                    | 24a. Was a autop perfor   | sy                       | prior to death?               | utopsy findings available completion of cause of s 2 No |
| Vital      | Physician:<br>this certific<br>ral director,   | Be                  | 25. Was case referred to medical examiner?  | Hospital:  |                                 |                                  |  | Otto                   |                          | of Death (Che                      | eck only o                | ne)                      | S                             | on's  |
| of         |  | . To                | 1 ☐ Yes 2 🔀 No<br>27. Manner of Death   | 28a. Date of (Month,   |                                 | ER/Outpatier<br>28b. Time o      |  | Othe<br>Injury<br>Work | 4 🗆 190                  |                                    | 5 Resid                   |                          |                               | Residence   |
| ion        | Attending I<br>r death.<br>ector: After<br>by the funer  | atlor               | 1 XNatural 5 ☐ Pending<br>2 ☐ Accident investiga  |  | Day Year)                       | Injury                           | м                                      |                        | ?<br>′es 2 🗌             | No                                 |                           |                          |                               |   |
| Division   | the state  | Certlflcation;      | 3 Suicide 6 Could no<br>4 Homicide determin   | and 200. Place of  | Injury - At h<br>, etc. (Specia | ome, farm, str                   | reet, factory, o                       | office                 |                          |                                    | ocation (S<br>lity or Tow |                          | Number or F                   | Rural Route Number,                                     |
|            | To the Hospital within 24 hours a To the Funeral Completely filled   | edical C            | 29a. Certifier (Check only one)  1 💢 Certifying 2 Medical E   | Physicien: To the base<br>xeminer: On the base<br>and manner       | is of examina                   | owledge, deat<br>ation and/or in | h occurred at<br>vestigation, in       | the tim                | e, date an<br>inion, dea | nd place, and death occurred at    | ue to the o               | cause(s) a<br>date and p | ind manner a<br>blace, and du | s stated.<br>e to the cause(s)                          |
|            |  | Me                  | 29b. Signature and title of certifier   | Ω.   | 1.                              | 1                                |  |                        | number                   |                                    | 1                         |                          |                               | th, Day, Year)  |
|            | 9  |                     | Jemish.   | ·12mm  | 4,11                            | N)                               |  | 7285                   | )                        |                                    |                           | Dece                     | mber 2                        | 5, 2005   |
| )          | 0  |                     | James A. Brown,   | M.D. 9707  | Medi                            | cal Cer                          |  | cive                   | e, Ro                    | ckville                            | e, Ma                     | rylar                    | nd 208                        | 50  |
|            | Sta<br>Regist  |                     | 31. Date filed (Month, Day, Year) DEC 2 8   | 2005   | istrar's Sign                   | Al.                              | ark.                                   |                        |                          |                                    |                           |                          |                               |   |

|                            |   |                   | For State   | State of Maryland   |                     |  |                   | nd Mer   | ntal Hy                            | 9                        | 005                         | 11770  |
|----------------------------|---|-------------------|---|---|---------------------|--|-------------------|--|------------------------------------|--------------------------|-----------------------------|--|
|                            |   |                   | Registrar  1. Decedent's Name (First, Middle, Last)   |   |                     | ertificate of  | Deam              | 2.   | Date of De                         | Reg. No.                 | 000                         | 3. Time of Death                                 |
|                            | Physicia  | an                | Edward  | Kenneth   | D-                  | wno.   |                   | 3  | Month<br>ELEW                      | REP Day                  | 26 200                      |  |
|                            | /Medic<br>Examin  |                   | 4a. Facility Name (If not institution, give s   |   | DC                  | 4b. City, Town,  | or Location of    |  | CPCT                               |                          | County of Dea               |  |
|                            | LAGIIIII  |                   | Baltimore un  | shingtonme  |                     | Contes<br>v) Hunder 1 Year   | Gler<br>Tunder 24 | Bus  | nie                                | A                        | nne 1                       | Grundel  |
|                            | Funeral<br>Director   |                   | 5. Social Security Number 6. Sex 1.00   | M 2□ F 86   | ast birthda<br>Yrs. | Months Days  |                   | Min.   | Date of Bir<br>(Month, Da<br>ne 24 | y, Year)                 | C                           | thplace (State or Foreign<br>ountry)<br>aryland  |
|                            |   |                   | Usual Residence of Decedent   |   |                     |  |                   | - Du   | IIC LT                             | , 17.                    | +2   11                     |  |
|                            | urylan<br>show  |                   | 10a. State 10b. County  | 10c. City   | , Town or           | Location   |                   |  |                                    |                          |                             | 10d. Inside City Limits 1 ☐ Yes 2 ☑ No           |
|                            | s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 Is marked other than "natural", or Items 23s or 28s-f show other treumatic avent, the Wedical Examinations in notified at   | Funeral Director  | Maryland Anne Arun  | del P   | asade               | na<br>10f. Zip Code  |                   | <u>.                                      </u> | Т                                  | 10g Citi:                | zen of What Co              |  |
|                            | with t  | Ö                 | 8427 Arbutus Road   |   |                     | 2112   | 22                |  |                                    | rog. o                   | U.S.                        |  |
|                            | ma 23   | era               |   | 2. Was Decedent Ever in U.  | S. 1:               | 3. Was Decedent of<br>If Yes, specify Cul                          |                   | n? (Specify                                    | Yes or No                          | D- 1                     | 14. Race - Ame              | erican Indian,                                   |
| 9                          | or Ite  | Fur               | 1 Never Married 2 Married   | Armed Forces?  1 MYes 2 □ No If Yes, Give 1944-1 Year or Dates:                     | 046                 | 1 ☐ Yes 2 ☑ No   |                   | Puerto Hici                                    | an, etc.)                          |                          | Black, White Specify:       |  |
| ANEY<br>21215-0036         | ural',  | Completed by      | 3 XWidowed 4 □ Divorced   |   |                     |  |                   |  |                                    |                          |                             | White  |
| मि स्                      | n 72 h  | olete             | 15. Decedent's Educ<br>(Specify only highest grade  | completed)  | (Gi                 | cedent's Usual Occu<br>ve kind of work done<br>i. DO NOT use retin | during most of    | of working                                     |                                    | 160. KII                 | nd of Business              | rindustry  |
| ALN nd 2121                | d with<br>giene.  | mo                | Elementary/Secondary (0-12)   | College (1-4or 5+)<br>5+  | Sı                  | perintend  | dent              |  |                                    | Ste                      | eel Com                     | pany   |
| 是 P                        | be filed<br>tal Hygi<br>d other<br>avent, t   | Bec               | 17. Father's Name (First, Middle, Last)   |   |                     |  | 18. Mother        | s Name (F                                      | irst, Middle                       | , Maiden                 | Sumame)                     |  |
| B A                        | ould to   | 2                 |   | arney   | 10: 11              |  |                   | trude  |                                    | Flin:                    | <u> </u>                    | To Code \  |
| Mar                        | d 2 sh<br>th and<br>7 la rr<br>treurr   |                   | 19a. Informant's Name/Relationship (Typ   |   |                     | Dooch Dwi  |                   |  |                                    |                          | 19904<br>19904              |  |
| 0                          | Heall<br>Heall<br>tem 2<br>other  |                   | Carol B. White  20a. Method of Disposition  |   | lace of Dis         | Beech Dri position (Name of rematory or other pl                   | 1                 | Date   |                                    |                          | cation - City or            |  |
| altimore,                  | Pages<br>nent of<br>int: If it<br>iry or o  |                   | 1 ☐ Burial 2 ☐ Cremation 3 ☐ Re   | emoval from State   |                     | Service (  |                   | 2-29-  | 2005                               | Tov                      | wson, M                     | aryland  |
| Balti                      | permit. Pages<br>Department of<br>Important: If it<br>any injury or c<br>once.  |                   | 21. Signature of Funeral Service License  |   |                     | 22. Name and Add   | ess of Facility   | Ruc  | k Tow                              | son                      | Funeral                     | Home, Inc.                                       |
| M                          | 20240   |                   | 23a. Part1. Enter the disease, or complic   | ations that caused the death  | n. Do not o         | 1050 York  |                   |  | son,                               |                          | ianu Z                      | 1204<br>Approximate                              |
|                            | Physician   |                   | shock, or heart failure. List only on<br>Immediate Cause (Final   | d cause on each line.   | 2-00                | O  | 1                 | 1  | -                                  |                          |                             | Interval Between<br>Onset and Death              |
|                            | /Medical  |                   | disease or condition resulting in death)  | Due to (or as a consequ   | uence of):          | un in  | Kun               | ~~~  |                                    |                          |                             |  |
|                            | Examiner  |                   | Sequentially list conditions  | metint  | Mil                 | line   | 0                 | mce  | R                                  |                          |                             |  |
| (A                         | sit ad  | Iner              | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | Due to (or as a consequ   | uence of):          | 0  |                   |  |                                    |                          |                             |  |
| 1                          | be executed<br>sician and<br>burial-transit   | Examiner          | that initiated events resulting in death) Last  | Due to (or as a consequ   | uence of):          |  |                   |  |                                    |                          |                             |  |
| 8760                       | e be e  |                   |   |   |                     |  |                   |  |                                    |                          |                             |  |
| 9                          | tificate<br>ng phys<br>as the   | ledi              |   |   |                     |  |                   |  |                                    |                          |                             |  |
| Вох                        | leath certifica<br>attending ph   | an/N              | 1F FEMALE:<br>23b. Was decedent pregnant<br>in the past 12 months?  | 3c. If yes, outcome of pregna<br>1 Live birth 2 Fetal                               | death               | 3 □Ectopic pregnan   | су                |  |                                    | 2                        | 23d. Date of de<br>Month    | livery<br>Day Year                               |
| P.O. E                     | ires that the dec<br>signed by the a  | Physician/Medical | 1 Yes 2 No  | 4□Pregnant at time of de<br>9□Unknown   | eath                | 5 Other (specify)  |                   |  |                                    |                          |                             |  |
|                            | s that in the property of the | by Ph             | Part II. Other significant conditions con   | tributing to death but not resu   | ulting in the       | underlying cause g   | oven in Part I.   |  | 23e. Did                           | tobacco u                | ise contribute t            | o the cause of death?                            |
| rds                        | w require<br>been sig<br>should b   |                   |   |   |                     | <u> </u>   |                   |  | 1 🗆                                | Yes 2[                   | □No 3 P                     | robably 4 Unknown                                |
| ec                         | e law re<br>has be<br>je 2 sh   | Completed         |   |   |                     |  |                   |  | 24a. Was                           | psy                      | prior to                    | utopsy findings available completion of cause of |
| <u>~</u>                   | : The l<br>cate ha  | Con               |   |   |                     |  |                   |  | perī<br>1 ☐ Yes                    | ormed?<br>2LXNo          | death?<br>1 ☐ Yes           | s 2 No   |
| Vits                       | sician: Th<br>certificate<br>rector, pag  | o Be              | 25. Was case referred to medical examiner?  | ospital:  | ED/0.4              | O  | thor              | of Death (C                                    |                                    |                          | 2 (201)                     |  |
| ō                          | Phys<br>ar this<br>eral di  | -                 | 1 Yes 29 No 27. Mappier of Death  | 28a. Date of Injury   | 28b. Time           | of 28c. Inj  | 4   Nurs          |  |                                    |                          | 6 □Other (Spe<br>y occurred | эспу)  |
| <u>io</u>                  | ittending F<br>death.<br>ctor: After<br>y the funeri  | atlo              | 1 Natural 5 ☐ Pending 2 ☐ Accident investigation  | (Month, Day Year)   | Injur               |  | ork?<br>∐Yes 2 □N | 0  |                                    |                          |                             |  |
| Division of Vital Records, | or Attending Physician: The law requires that the death certificate be executed after death. Diractor: After this certificate has been signed by the attending physician and in by the funeral director, page 2 should be detached for use as the burial transit  | Certification:    | 3 Suicide 6 Could not be 4 Homicide determined  | 28e. Place of Injury - At he building, etc. (Specify                                | ome, farm,          | street, factory, office  | 9                 | 28f  | Location<br>City or To             | (Street and<br>wn, State | d Number or A<br>)          | ural Route Number,                               |
| ū                          | To the Hospitel or Attenwithin 24 hours after deatl To the Funeral Diractor:  | edical Ce         |   | sician: To the best of my kno<br>ner: On the basis of examina<br>and manner stated. |                     |  |                   |  |                                    |                          |                             |  |
| _                          | ro the vithin is ro the comple  | Me                | 29b. Signature and title of certifier   | and marries stated.   |                     | 29c. Lice  | nse number        |  |                                    | 29d. Dat                 | te signed (Mon              | th, Day, Year)                                   |
|                            | , ,, , ,  |                   | 1 Azotor  | MAS   |                     | DA   | 3977              | 7  |                                    |                          | uber a                      | ab 2005  |
|                            | 15+1  |                   | 30. Name and address of person who co   | mpleted cause of death (Item  | 1 23a) (Typ         | PRINCE Q   | len Be            | ime  | · M                                | 5 2                      | 1061.                       |  |
|                            | Sta   |                   | 31. Date filed (Month, Day, Year)   | 32. Registrar's Signa   | ture                | المكار   |                   |  |                                    |                          | 12-1                        |  |
|                            | Registr   | ar                | DEC 2 8 2005  | Destro 10.  | 17                  |  |                   |  |                                    |                          |                             |  |

|   |   |                     | 1 - For<br>State<br>Registrar   | State of M   | aryland .         |                          | artmen                              | t of H                     | lealth and                                    |                             | al Hygie                          | _                            |                        | 1.1770  |
|---|---|---------------------|---|--|-------------------|--------------------------|-------------------------------------|----------------------------|---|-----------------------------|-----------------------------------|------------------------------|------------------------|---|
| ľ                                       | Act of  | TV.                 | Decedent's Name (First, Middle, I   | .ast)  |                   |                          |                                     |                            |   |                             | te of Death                       |                              | 20                     | 3. Time of Death                              |
| - (条)                                   | Physici<br>/Medic   |                     | Natividad   | Bucaneg  |                   |                          |                                     |                            |   |                             | onth<br>1 Z                       | 2S                           | Year                   | 1100 M  |
| )                                       | Examir  |                     | 4a. Facility Name (If not institution, g  |  |                   |                          |                                     |                            | Location of De                                |                             |                                   | 4c. County                   | of Death               |   |
| - 1                                     |   |                     | Union Memorial  5. Social Security Number 6.  |  | je (in yrs. last  | to inthomator)           |                                     | timo<br>1 Year             | re City                                       |                             | to of Dist                        | n/a                          |                        |   |
|   | Funeral<br>Director   |                     | 293–52–4682 Usual Residence of Decedent   | 1 M 2 X F  | 70                | Yrs.                     | Months                              | Days                       | Hours Mi                                      | n. ( <i>M</i> i             | te of Birth onth, Day, Yo         | 1935                         | Cour                   | place (State or Foreign<br>htry)<br>ilippines |
|   | yland   |                     | 10a. State 10b. County  |  | 10c. City, T      | own or Lo                | cation                              |                            |   |                             |                                   |                              | 1                      | 0d. Inside City Limits                        |
|   | Ba-f s  | ctor                | MD n/a  |  | Bal               | timo                     | ce                                  |                            |   |                             |                                   |                              |                        | 1 □Yes 2 No                                   |
|   | uth with th   | ral Dire            | 10e. Street and Number<br>2644 N. Charle  | es Street  |                   |                          | 10f. Zip                            |                            | 18-4513                                       |                             | 10g.                              | Citizen of W                 | /hat Cour              | ntry?   |
| 036                                     | permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show says injury or other traumatic event, Ira Medical Examinat rausifie an appea. | by Funeral Director | 11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 🛣 Divorced               | 12. Was Decedent<br>Armed Forces?<br>1 Yes 2 N<br>If Yes, Give<br>Year or Dates: | -                 |                          | Was Deced<br>f Yes, spec<br>1 ☐ Yes |                            | spanic Origin?<br>n, Mexican, Pue<br>Specify: | (Specity Ye<br>erto Rican,  | es or No-<br>etc.)                |                              | k, White,              | en Indian,<br>etc.<br>nite                    |
| 21215-0036                              | ithin 72 hol<br>nen "natura<br>e Medical E  | Completed           | 15. Decedent's<br>(Specify only highest of<br>Elementary/Secondary (0-12)               | rade completed) Coltege (1-4or :   | 5+)               | (Give<br>life. l         | DO NOT us                           | rk done d<br>se retired    | furing most of w<br>)                         | rorking                     |                                   | o. Kind of Bu                |                        | dustry  |
| 72                                      | lled w<br>hygier<br>thar th   |                     | 17. Father's Name (First, Middle, La.   | 4  | M                 | edica                    | al Te                               | chno:                      | logist<br>18. Mother's N                      | ama (Firet                  |                                   |                              |                        |   |
| Maryland                                | ld be f<br>ental h<br>ked of  | To Be               |   | <br>Lguito   |                   |                          |                                     |                            | Marce:  |                             |                                   | entino                       | •                      |   |
| ary                                     | shou<br>and M<br>smar<br>sumat  | ۲                   | 19a. Informant's Name/Relationship  | (Type, Print)  | 1                 | 19b. Mailin              | g Address                           | (Street a                  | and Number or F                               | Rural Route                 | e Number, C                       | ity or Town,                 | State, Zip             | Code)   |
|   | and 2<br>lealth<br>m 27 I   |                     | Robin T. Myaing/  | /nephew  |                   |                          |                                     |                            | nase Dr:                                      |                             |                                   |                              |                        |   |
| Baltimore,                              | nt of H   |                     | 20a. Method of Disposition 1 ⊠ Burial 2 □ Cremation 3                                   |  | i                 | etery, cren              | natory or o                         | ther place                 | - 1   | Date                        | NK 200                            |                              |                        |   |
| 를                                       | artme<br>ortant<br>injury   |                     | 4 □ Donation 5 □ Other (Spec<br>21. Signature of Fun □ Servire ic                       |  | San F             | -                        |                                     |                            |   | Ruck                        |                                   |                              |                        | ippines<br>Home, Inc.                         |
| B                                       | Depa<br>Depa<br>Impo<br>eny iv  |                     | Mendo to  | Os. D. Co  | ster              |                          |                                     |                            | Road,   |                             |                                   |                              | 212                    |   |
|   | T)  |                     | 23a. Part1. Enter the disease, or co<br>shock, or heart failure. List on                | mplications that caused  | the death. D      | Do not ente              | er the mod                          | e of dying                 | g, such as cardi                              | ac or respi                 | ratory arrest,                    |                              |                        | Approximate<br>Interval Between               |
| - 42                                    | Physician<br>/Medical   |                     | Immediate Cause (Final disease or condition resulting in death)                         | a. Met   | ustati            | cu                       | tero                                | ) - 0                      | varia   | n (                         | me                                |                              |                        | Onset and Death                               |
| 1 | Examiner  |                     |   |  | a consequent      | ce of):                  |                                     |                            |   |                             |                                   |                              |                        |   |
|   |   | ner                 | Sequentiatly list conditions, if any, leading to immediate cause. Enter Underlying      | b. Due to (or as   | a consequenc      | ce of):                  |                                     |                            |   |                             |                                   |                              |                        |   |
| H                                       | te be executed<br>ysicien and<br>te burial-transit  | Examiner            | Cause (Disease or injury that initiated events resulting in death) Last                 | C  |                   |                          |                                     |                            |   |                             |                                   |                              |                        |   |
| 60,                                     | be exe  | ical Ex             | resulting in death) Last  | Due to (or as  | a consequent      | ce of):                  |                                     |                            |   |                             |                                   |                              |                        |   |
| 587                                     | phys<br>s the   |                     | ***   | d  |                   |                          |                                     |                            |   |                             |                                   |                              | -                      |   |
| .O. Box 68760,                          | es that the death certificate be executed igned by the attending physicien and be detached for use as the buriat transit  | Physician/Med       | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown | 23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown                        | 2 Fetal dea       | ath 3□                   | Ectopic pr<br>Other (sp             |                            |   |                             |                                   | 23d. Date<br>Mon             |                        | ry<br>Day Year                                |
| ۵.                                      | that the ed by detac  | / Ph)               | Part II. Other significant conditions   | contributing to death b  | ut not resultin   | g in the ur              | nderlying c                         | ause give                  | n in Part I.                                  | 23                          | le. Did tobac                     | co use contri                | bute to th             | e cause of death?                             |
| rds                                     | quires<br>n sign<br>uld be  | ed by               |   |  |                   |                          |                                     |                            |   |                             | 1 🗆 Yes                           |                              |                        | ably 4 EUnknown                               |
| Reco                                    | Physician: The law requires that the this certificate has been signed by the tal director, page 2 should be detach  | Completed           |   |  |                   |                          |                                     |                            |   | 24                          | a. Was an<br>autopsy<br>performed | . pi                         | lere autor             | osy findings available inpletion of cause of  |
| ā                                       | an: T   | 0                   | 25. Was case referred to medical  |  |                   |                          |                                     |                            | 26. Place of De                               |                             | Yes 212                           | No 1                         | ☐ Yes                  | 2 No -  |
| <u>&gt;</u>                             | hysici<br>his ce<br>I direc   | To B                | examiner?<br>1 ☐ Yes 2 ☐ No   | Hospital:<br>1 ☐ Inpatie   | ent 2 ER/         | Outpatien                | t 3□ DO                             | Othe                       |   |                             |                                   | e 6 □Othe                    | r (Specify             | ')  |
| Division of Vital Records,              | Attending Planding Planding Planding Planding Planding Getor: After the funeral by the funeral  | Certification:      | 27. Manner of Death  1 Natural 5 Pending 2 Accident investigati                         |  | ry 28t<br>y Year) | b. Time of<br>Injury     | M 2                                 | 8c. Injury<br>Work<br>1  Y | at<br>?<br>′es 2 □ No                         | 28d. De                     | escribe how i                     | njury occurre                | d                      |   |
| <u>X</u>                                | 호ૂ 및 무슨   |                     | 3 Suicide 6 Could not determine   | d 288. Place of Inj<br>building, et  | c. (Specify)      |                          |                                     |                            |   | Cit                         | y or Town, S                      | tate)                        |                        | l Route Number,                               |
|   | Hospital 24 hours a Funeral i etely filled  | Medicai             | 29a. Certifier 1 Certifying F (Check only one) 2 Medical Ext                            | Physician: To the best<br>aminer: On the basis of<br>and manner sta              | examination       | dge, death<br>and/or inv | occurred a estigation,              | at the tim<br>, in my op   | e, date and plac<br>inion, death occ          | ce, and due<br>curred at th | to the cause<br>to time, date     | e(s) and mar<br>and place, a | ner as st<br>nd due to | ated.<br>the cause(s)                         |
|   | To the within 2 To the complet  | Me                  | 29b. Signature and fittle of certifier  |  |                   |                          |                                     | . License                  |   |                             |                                   | Date signed                  |                        |   |
| )                                       |   |                     | Wellen  | MAX  | M                 | .0                       |                                     | D                          | 60581   |                             | D                                 | lcem                         | ber                    | 25,2005                                       |
|   | 10  |                     | 30. Name and a dress of person who  | complet d cau e of d   | eath (Item 23     | a) (Type,                | rint)                               | Λ                          |   | H                           | colti.                            | 0                            |                        | 25,2005                                       |
| 1                                       | Sta   | 40.00               | 31. Date filed (Month, Day, Year)   | 32. Registr  | ar's Signature    | and the                  | ۱۱ ۲۰ ۱                             | in                         | corrar  | , 10                        | 7                                 |                              |                        |   |
|   | Registr   | ar                  | DEC 2 8 200   | De Marie   | 10. 10            |                          |                                     |                            |   |                             |                                   |                              |                        |   |

Amend item#10e, perFH, C850, 12-30-05 TT State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death December 23 **Physician** 7:35 a M Marie E. Combs /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Towson Baltimore Gilchrist Center for Hospice Care 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) JAN 30 1960 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🖾 F 45 215-50-1226 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show itam 27 is marked other than "natural; or itams 23a or 28a-f eho other traumatic event, it a Mudical Examinar must be notified at 1 Yes 2 No Director MDBaltimore Baltimore 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 21227 USA 233 Green Fern <del>Was</del> 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1⊠ Yes 2□ No Specify: Mexican Baltimore, Maryland 21215-0036 Specify: white þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 12 should be filed within 7 h and Mental Hygiene.
7 Is marked other than "n Elementary/Secondary (0-12) College (1-4or 5+) Heating & Plumbing 12 Purchasing Agent 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ramirez Frances Irene Klier Augustine Lopez 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If Itam 27 Is m eny injury or othar traum once. John Combs - husband 233 Green Fern Way, Baltimore, MD 21227 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory 12/24/2005 Beltsville, MD 21. Signature of Funeral Service Licensee CAFA, Stephen D. Lohrmann, PA 8717 Green Pastures Drive, Towson, MD 21286 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** malignant mesothellamo disease or condition resulting in death) months /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine The law requires that the death certificate be executed physician and s the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 W No
9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 3 Ectopic pregnancy Month 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed?
1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physicien: 25. Was case referred to medical examiner? Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other 4 Nursing Home 5 Residence 6 Other (Specify) NOSPI 4 ٩ 1 ☐ Yes 2 No 28a. Date of Injury (Month, Day Year) 27. Manner of Death Natural 28c. Injury at Work? 28b. Time of Certification: 28d. Describe how injury occurred 5 Pending investigation Injury 1 Yes 2 No 2 Accident hours after death uneral Director: 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 - Homicide within 24 hours a To the Funeral I completely filled Certifier (Check only one)

Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D58203 arerm December 23 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Charles ST POWSEN MD ZIZOU 6601 N. AARON CHARLES MO 32. Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

DEC 2 8 2005

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Ε. December 24 2005 12:30 p /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1519 Marshall Street Baltimore N/A 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) MAR 17 194 7. Age (In vrs. last birthday) Birthplece (State or Foreign Country) **Funeral** 1∰M 2□F 218-36-0947 64 Director 1941 MD Usuel Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show ?7 is marked other than "natural", or items 23s or 28s-f shov traumatic event, the Medical Examiner maint by multifal at 1 Yes 2 No Director MD N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1519 Marshall Street 21230 Pages 1 and 2 should be filed within 72 hours after death Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 💢 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛛 No Specify: Specify: white 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 18b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Coltege (1-4or 5+) Sanitation Worker City Public Works 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Health and Mental Marshal Ε. Crowe Anna Mae Beeman 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ruth A. Gore - daughter 2900 Bristol Channel Ct., Pasadena, MD If item 27 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If ite
any injury or ot 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State \* 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory 12/27/2005 Beltsville, MD Name and Address of Facility FA, Stephen D. Lohrmann, 17'Green Pastures Drive; 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) MTherosclarotic /Medical Due to (or as a consequence of): Examiner yper tension Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last to (or as a consequence of) Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of): P.O. Box 68760. attending physician Completed by Physician/Medical as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No the 9 Unknown 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. 1 ☐ Yes 2 ☐ No 3⊠Probably 4 □Unknown peen s 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an has autopsy performed certificate 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No this in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification; After 5 Pending investigation 1. Natural death. 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Diractor: 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signaturé and title of certifie US3517 ess of person who completed cause of death (Item 23a) (Type, Print) 301 Saint Paul Place Protessional Office Building 907 Baltimore Maryland 21202 MENDOZA 1AGLE 31. Date filed (Month, Day, Year)
DEC 2 8 32 Registrar's Signature State 2005 Registrar

|                            |   |                | For<br>State<br>Registrar   | State of Marylai                                  |  | ent of Health and<br>ate of Death                         | d Mental Hy                   | giene 05                   | 41782   |
|----------------------------|---|----------------|---|---|--|---|-------------------------------|----------------------------|---|
|                            |   |                | 1. Decedent's Name (First, Middle, Last)  |   | ~  |   | 2. Date of D                  | eath<br>Day Year           | 3. Time of Death  |
|                            | Physici<br>/Medic   |                | Mary Eliza  | bern Coope  | er-Dun                                   | bar   | Dec.                          | 23, 2005                   | 7:30 AM   |
|                            | Examin  | er             | 4a. Facility Name (If not institution, give s   |   |  | City, Town, or Location of D                              |                               | 4c. County of Deat         |   |
|                            |   |                | 5. Social Security Number 6. Sec  | More Nursi  |  | Yallsville  | Maryland<br>Hrs. B. Date of B | at Dia                     |   |
|                            | Funeral<br>Director   |                |   | M 2 F 75  |  |   | lin. (Month, D                | lay, Year) A Co            | hplace (State or Foreign<br>untry)<br>1910 N. VV (1010) |
|                            |   |                | Usual Residence of Decedent   |   |  |   |                               |                            | 51441   |
|                            | ahow  | _              | 10a. State 10b. County  |   | ity, Town or Location                    | DC  |                               |                            | 10d. Inside City Limits                                 |
|                            | 8a-f  | Director       | N/A N/A   | 9676  | dshington                                | •   |                               |                            |   |
|                            | with the  |                | 10e. Street and Number  | 1 Carolin   |  | . Zip Code  |                               | 10g. Citizen of What Co    | untry?  |
|                            | eath<br>rust  | by Funeral     | 602 EMManus   | 12. Was Decedent Ever in U                        | V. W. 2                                  | ecedent of Hispanic Origin?                               | /Specify Yes or N             | 0- 14. Race - Ame          | rican Indian  |
| "                          | r Iten  | Fig            | 1 Never Married 2 Married   | Armed Forces?<br>1 ☐ Yes 2 ☐ No                   |  | ecedent of Hispanic Origin?<br>specify Cuban, Mexican, Po | uerto Rican, etc.)            | Black, White               |   |
| 93                         | hours after death with the Maryland<br>tural', or Items 23a or 28a-f show<br>al Exprilingt must be invitited at   |                | 3 ☑ Widowed 4 □ Divorced  | If Yes, Give<br>Year or Dates:                    | 1 □ Ye                                   | s 2 No Specify:   |                               | Specify: Bi                | ack   |
| 5-0                        | be filed within 72 hours after death with the Marylan ital Hygiene. Id other than "natural", or Items 23a or 28a-f show of other than "natural", or Items 23a or 28a-f show event, the Medical Examinar must be notified at | Completed      | 15. Decedent's Edu<br>(Specify only highest grade   | cation<br>completed)                              | 16a. Decedent's (Give kind o             | f work done during most of                                | working                       | 16b. Kind of Business/     | Industry  |
| 121                        | within 72<br>ene.<br>than "nal  | Id III         | Elementary/Secondary (0-12)   | College (1-4or 5+)                                |  | Taker   |                               |                            | 12.71   |
| d 2                        | filed withi<br>Hygiene.<br>other than   |                | 17. Father's Name (First, Middle, Last)   |   | Care                                     |   | Name (First, Middle           | e, Maiden Sumame)          | ABN' AL   |
| an                         |   | To Be          | Emanuel Coop  | DY.   |  | 4   |                               | Cooper                     |   |
| Maryland 21215-0036        | S D E E   | -              | 19a. Informant's Name/Relationship (Ty  | pe, Print)  | 19b. Mailing Add                         | ress (Street and Number or                                |                               |                            | Tip Code)   |
|                            | 1 and 2 s<br>Health ar<br>am 27 ls  |                | Ragina Martin 1   | todge/Daught                                      | er 602 En                                | imanuel Cou   | RT N.W, #                     | 204 Wash, D.               | C-20001   |
| ore                        | es 1 and of Healt filam 2   |                | 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ R   | 20b.  | Place of Disposition cemetery, crematory | (Name of or other place)                                  | Date                          | 20c. Location - City or    |   |
| Ĕ                          | Pages<br>ment of<br>ant: If It<br>ury or o  |                | '4 □Donation 5 □Other (Specify)   | Ho  | drmony h                                 | lemoval 30  | Dec. 05                       | Landover N                 | laryland  |
| Baltimore,                 | permit. Pages Department of I Important: If Its any injury or of  |                | 21. Signature of Funeral Service License  | 96,   | 22. Nam                                  | e and Address of Facility                                 |                               |                            |   |
|                            | <b>2</b> □  |                | 7 cups he   | (gme)   | 383                                      |   |                               | - N.W. Wash.               |   |
|                            |   |                | 23a. Part1. Enter the disease, or compliant shock, or heart failure. List only or                   | ne cause on each line.                            | ith. Do not enter the                    | mode or dying, such as care                               | alac or respiratory           | arrest,                    | Approximate<br>Interval Between<br>Onset and Death      |
|                            | Physician /Medical  |                | Immediate Cause (Final disease or condition resulting in death)                                     | Cardiose  | spirator                                 | y toul  | ire.                          |                            |   |
|                            | Examiner  |                | - 1   | AHA A & OC  | cleroti                                  | midias  | mac. 1.                       | er disease                 | 2   |
|                            |   | ler            |   | Due to (or as a conse                             |  | Caraco  | escure.                       | er deser                   |   |
|                            | outed<br>id<br>ansit  | Examiner       | if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events |   |  |   |                               |                            |   |
| ó                          | sician and<br>burial-transit  |                | resulting in death) Last  | Due to (or as a conse                             | quence of):                              |   |                               |                            |   |
| 8760                       | cate be executed<br>physician and<br>the burial-transit   | dlcal          |   | J   |  |   |                               |                            |   |
| 9                          | ertific<br>ling p   | Med            | IF FEMALE:  | 0 11 11 11 11 11 11 11 11 11 11 11 11 11          |  |   |                               |                            |   |
| Вох                        | eath certific<br>attending p  | lan/           | in the past 12 months?  | 3c. If yes, outcome of pregr                      | al death 3 □Ectop                        | ic pregnancy  |                               | 23d. Date of deli<br>Month | very<br>Day Year  |
| -                          | that the de<br>ted by the a<br>detached t   | Physician/Me   | 1 ☐ Yes 2 ☑ No<br>9 ☐ Unknown   | 4☐Pregnant at time of<br>9☐Unknown                | death 5 ☐ Othei                          | (ѕреспу)  |                               |                            |   |
| P.0                        | that i  |                | Part II. Other significant conditions cor   | ntributing to death but not re                    | sulting in the underlyi                  | ng cause given in Part I.                                 | 23e. Did                      | tobacco use contribute to  | the cause of death?                                     |
| rds                        | quires<br>n sign  | d by           | COPD  |   |  |   | _ 1 🗆                         | Yes 2 No 3 Pro             | obably 4 Unknown  |
| 00                         | law require<br>as been sig<br>2 should b  | olete          | obesity   | -   |  |   | 24a. Wa                       | s an 24b. Were au          | topsy findings available                                |
| Re                         | 0 = 0   | Completed      |   |   |  |   | — auto perf 1 ☐ Yes           | ormed? death?              | completion of cause of                                  |
| ital                       | ysician: Thi<br>is certificate<br>director, pag   | Be C           | 25. Was case reterred to medical examiner?  |   |  | 26. Place of I  | Death (Check only             |                            |   |
| × ×                        | Physician:<br>this certific<br>al director,   | ပ္             | 1 ☐ Yes 2 ☑ No  |   |  |   |                               | idence 6 Other (Spec       | cify)   |
| N C                        |   | :по            | 27. Manner of Death 1 ☑ Natural 5 ☐ Pending   | 28a. Date of Injury<br>(Month, Day Year)          | 28b. Time of<br>Injury                   | 28c. Injury at<br>Work?                                   | 28d. Describe                 | how injury occurred        |   |
| Division of Vital Records, | ten<br>leath<br>tor:<br>the   | Certification; | 2 Accident investigation 3 Suicide 6 Could not be   | 28e. Place of Injury - At I                       | M Some farm street fa                    | 1 Yes 2 No  | 28f Location                  | (Street and Number or Ru   | ra l Poute Number                                       |
| Ď                          | I or Attendation of the Director:   | ertlf          | 4 Homicide determined   | building, etc. (Spec                              | ify)                                     | ctory, office   |                               | own, State)                | rai noute ivalilibei,                                   |
|                            | To the Hospital or At within 24 hours after d To the Funeral Direct completely filled in by   |                | 29a. Certifier 12 Certifying Phys   | sician: To the best of my kn                      | lowledge, death occur                    | red at the time, date and pla                             | ace, and due to the           | cause(s) and manner as     | stated.   |
|                            | n 24 h  | edical         | (Check only 2 Medical Examination one)  | ner: On the basis of examin<br>and manner stated. | ation and/or investiga                   | tion, in my opinion, death o                              | ccurred at the time           | , date and place, and due  | to the cause(s)   |
|                            | To the Hospital or A within 24 hours after To the Funeral Direcompletely filled in by   | W              | 29b. Signature and title of certifier   |   | A 1 4                                    | 29c. License number                                       |                               | 29d. Date signed (Month    |   |
| )                          |   |                | · Uff   | uner  | /VID .                                   | 6099  | 19                            | 12/28                      | 105   |
| 5                          | 0   |                | 30. Name and address of person who co   |   |  | 20010   |                               |                            |   |
|                            | Sta   | te             |   | 32. Signistrar's Sign                             | nature                                   | 20010   | )                             |                            |   |
|                            | Registr   |                | 31. Date filed (Month, Day, Year)<br>DEC 2 8 20   | 05 Jacque   | natura (Spans                            | E)  |                               |                            |   |

|                            | I de la companya de la companya de la companya de la companya de la companya de la companya de la companya de  |                   | 1 - For<br>State<br>Registrar  | State of Maryla  |  | artmen<br>rtificat                              |                            |  | Mental Hy                                 | giene<br>Reg. No.            | 05  | 417                                   | 83                    |
|----------------------------|--|-------------------|--|--|--|---|----------------------------|--|---|------------------------------|---|---------------------------------------|-----------------------|
| 育                          | Physici<br>/Medic  |                   | 1. Decedent's Name (First, Middle, Last)  Dominick J. Chr:   | istello Sr.  |  |   |                            |  | 2. Date of D                              | Day                          | 200   | 3. Time (                             | Of Death<br>A M       |
|                            | Examir   |                   | 4a. Facility Name (If not institution, give s  Bel Air Heal  5. Social Security Number 6. Sex  | Ma Rehat   | Cent   |   | 13                         | Location of De                               | IS. 8 Data of Ri                          | / /                          | Har S   | ford                                  | or Foreign            |
|                            | Funeral<br>Director  |                   |  | M 2□F 89   |  | Months  | Days                       | Hours M                                      |   | 2, 191                       | 6 Pa  | nplace (State<br>untry)               | or roreign            |
|                            | e Marylan<br>la-f show   | Director          | 10a. State 10b. County 10b. Baltime  |  | ity, Town or Lo<br>Dunda   |   |                            |  |   |                              |   | 10d. fnside (                         | City Limits           |
|                            | th with th   | ai Dire           | 10e. Street and Number<br>1902 Madison Rd.   |  |  | 10f. Zip  | 212                        | 22   |   | 10g. Cîtizen<br>US           | of What Co                                      | untry?                                |                       |
| 900                        | permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Plygiene. Important: If Item 27 is marked other then "natural", or Items 23e or 28s-1 show any injury or other traumatic event. The Medical Exam the must be coulded at anote. | d by Funeral      | 11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced   | 2. Was Decedent Ever in the Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates:               |  | Was Deced<br>f Yes, spec<br>1  Yes              |                            | spanic Origin?<br>n, Mexican, Pu<br>Specify: | (Specify Yes or Nerto Rican, etc.)        |                              | Race - Ame<br>Black, White<br>ecify: Wh         |                                       |                       |
| Maryland 21215-0036        | d within 72 h<br>giene.<br>er then "natu   | Completed         | 15. Decedent's Educ<br>(Specify only highest grade<br>Elementary/Secondary (0-12)<br>8 yrs.  |  |  | dent's Usua<br>kind of wo<br>DO NOT u.<br>oller | rk done d<br>se retired)   | tion<br>uring most of w                      | vorking                                   | 16b. Kind o                  | of Business/l                                   | ndustry                               |                       |
| yland                      | ould be file<br>Mental Hy<br>arked othe  | To Be C           | 17. Father's Name (First, Middle, Last) Giro Christello  | C  |  |   |                            |  | lame (First, Middle<br>G. Vita            |                              | mame)   |                                       |                       |
| , Mar                      | and 2 sho<br>salth and<br>n 27 Is my<br>lar traums   |                   | 19a. Informant's Name/Relationship (Ty) Frances Christel   | lo wife  | 190  | 2 Mad   | ison                       | Rd. Du                                       | Rural Route Numb<br>indalk Md             |                              |   | îp Code)                              |                       |
| Baltimore,                 | Pages 1<br>ment of H<br>ant: If Iter<br>iury or oth  |                   | 20a. Method of Disposition 1 ☑Buriaf 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)  | emoval from State St   | Place of Dispo<br>cemetery, cren<br>Stan   | natory`or o                                     | ther place                 | em. De                                       | ec. 29,<br>2005                           |                              | ion - City or 1<br>dalk M                       |                                       |                       |
| Balt                       | permit<br>Depart<br>Import<br>any inj  |                   | 21. Signal, e of Fuyers Service License  | Sh   | /  | 110 S   | orre                       | rs Poin                                      | Home Of 1<br>t Rd. 21                     | 222                          | k   |                                       |                       |
| të.                        | Physician<br>/Medical<br>Examiner  |                   | 23a. Part Y. Enter the disease, or complishood in heart failure. List only on Immediate Cause (Final disease or condition resulting in death)            | e cause on each line.  | eumor  | *   | le of dying                | , such as card                               | iac or respiratory a                      | rrest,                       |   | Approxima<br>Interval Be<br>Onset and | tween                 |
| 8760,                      | icate be executed physician and s the burial-transit   | al Examiner       | Sequentially list conditions, if any leading to immodate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | Due to (or as a conse  | 4445   |   |                            |  |   |                              |   |                                       |                       |
| P.O. Box 687               | The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit   | Physician/Medical | fF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  | ac. If yes, outcome of pregn<br>1 □ Live birth 2 □ Fet<br>4 □ Pregnant at time of<br>9 □ Unknown | aldeath 3⊡   | Ectopic pr                                      |                            |  |   | 23d.                         | . Date of deliment                              | very<br>Day                           | Year                  |
| rds, P                     | quires that<br>en signed b<br>ould be deta   | þ                 | Part II. Other significant conditions con  | tributing to death but not re  |  |   | ause give                  | n in Part I.                                 |   | tobacco use o                |   | the cause of                          |                       |
| Division of Vital Records, | Physiclan: The law re<br>this certificate has be<br>al director, page 2 sho  | Completed         |  |  |  |   |                            |  | 24a. Was<br>auto<br>perfo<br>1  Yes       | psy<br>prmed/                | 4b. Were aut<br>prior to c<br>death?<br>1 □ Yes | opsy findings<br>ompletion of         | available<br>cause of |
| Zi Zi                      | Physiclan: Th<br>rthis certificate<br>ral director, pag  | o Be              | 25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No  | ospitaf:   | ] ER/Outpatien   |   | Othe                       |  | eath Check only                           |                              | 10.1 (0   |                                       |                       |
| ion of                     | Attending Physic death. ector: Atter this by the funeral dir   | $\vdash$          | 27. Manner of Death  1 Matural 5 Pending  2 Accident investigation   | 28a. Date of Injury<br>(Month, Day Year)   | 28b. Time of<br>Injury   | -   | 8c. Injury<br>Work         |  | Home 5 Resi                               |                              |   | ity)                                  |                       |
| Divis                      | or the   | Certification;    | 3 Suicide 6 Could not be determined  | 28e. Place of Injury - At building, etc. (Special  | nome, farm, stre   | eet, factory                                    | r, office                  |  | 28f. Location (<br>City or To             | Street and No<br>wn, State)  | umber or Rui                                    | ral Route Nur                         | nber,                 |
|                            | To the Hospital within 24 hours a To the Funaral Completely filled   | edical (          | 29a. Certifier 1 Certifying Phys (Check only one) 2 Medical Exemin   | icien: To the best of my kn<br>er: On the basis of examin<br>and manner stated.                  | owledge, death<br>ation and/or inv   | occurred<br>estigation                          | at the time<br>, in my opi | e, date and pla<br>nion, death oc            | ce, and due to the<br>curred at the time, | cause(s) and<br>date and pla | d manner as<br>ce, and due                      | stated.<br>to the cause(              | s)                    |
| 1                          | To I<br>To I   | Σ                 | 29b. Signature and title of certifier  |  |  | 290   | . License                  |  | 13  | 29d. Date sig                |   |                                       | m 4 /5 /              |
| 1                          | 1  |                   | 30. Name and address of person who con   | npleted cause of death (fte  | m 23a) (Type.  | Print)  | - 4                        | 0 250  | 12  | DEC                          | EMBE  | 16 21                                 | , 2006                |
|                            | l C  | to H              | J. Keura L.  | 22. Registrar's Sign   | Z<br>ature   | No  | rth                        | Ave.   | Bel                                       | Air                          | 1 M   | d. 21                                 | 1014                  |
| -                          | Sta<br>Registr   | _                 | DEC 2 8 2005   | State II   | A CONTRACTOR OF THE PARTY OF TH |   |                            |  |   |                              |   |                                       |                       |

Christello, Dominick J

State of Maryland / Department of Health and Mental Hygieme Certificate of Death 2. Date of Death 3. Time of Death 1 Decedent's Name (First, Middle, Last) **Physician** December 23, 2005 11:30pm Ruth Lugar Cornmesser /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Lorien Assisted Living Carrol1 Mt. Airy If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** 1 ▼M 2 □ F 87 PA 201-05-7668 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b County 10a. State or 28e-f show the Medical Examiner must be notified at 1 ☐ Yes 2 → No Directo MD Carroll Eldersburg 10g, Citizen of What Country? 10f. Zip Code 10e. Street and Number Items 23a 1585 Brimfield Circle 21784 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 5 1 ☐ Yes 2 ☑ No Baltimore, Maryland 21215-0036 Specify: Specify: White þ "natural", Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) than College (1-4or 5+) permit. Pages 1 and 2 should be filed will Department of Health and Mental Hyglen. Important: If Item 27 is marked other that any niury or other treumatic event, Item once. Domestic 12 Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be George Lugar Laura Eachus 19a. Informant's Name/Relationship (Type, Print) 19b. Maifing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Lois Barkdoll (Daughter) 1585 Brimfield Circle Eldersburg, MD 21784 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a, Method of Disposition 1 ☐ Burial 2 DCremation 3 ☐ Removal from State 12/27/05 All County Cremation Sykesville, MD \* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee HAIGHT FUNERAL HOME & CHAPEL, PA (Box 195) Sykesville, MD 21784 (410)-795-1400 Mar tel 23a. Part 1. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) tailure to those with carnexia Mas **Physician** /Medical Due to (or as a consequence of): Examiner Due to (or as a consumer of): Stro porosis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner executed burial-transit pettinsion and Due to as a consequence of): Box 68760. attending physician 413 tibrilation The law requires that the death certificate be Physiclan/Medical for use as IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) P.O. detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Dther significent conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ð page 2 should be Gastraesuphocieal Reflux 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No disorde 1 Yes 2 **X**No 1 Yes Hospitel or Attending Physicien: 25. as case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? After 5 Pending 1 Natural 1 ☐ Yes 2 ☐ No investigation 24 hours after death. Funerel Director: A 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of fnjury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 - Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical npletely (Check only one) within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature titles for rtifler D54749 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) House Are. D-1, FREDERICK, MD 21701 Reing 801/016 32 Registrar's Signature 31. Date filed (Month, Day, Year) State DEC 2 8 2005 Registrar

|                     |   |                   | 1 - State of Maryland / Department of Health and Certificate of Death  |   | 2005 41785  |
|---------------------|---|-------------------|--|---|---|
| *                   | Physici   |                   | 1. Decedent's Name (First, Middle, Last)  Roland Edward Clingman   | 2. Date of Death<br>Month<br>December         | Day Year 2  |
|                     | /Medic<br>Examin  |                   | 4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death  BALTIMORE WAShINGTON Medical Centre GLEN BURNTE  5. Social Security Number  6. Sex  7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.        | h<br>E  | 4c. County of Death ANNE ARLINDEL                                       |
|                     | Funeral<br>Director   |                   | 218-32-8596 17 M 2 F 71 Yrs. Months Days Hours Min.  | April 26                                      | 9. Birthplace (State or Foreign<br>Maryland                             |
|                     | e Maryland<br>la-f ehow<br>illied at  | ctor              | 10a. State 10b. County 10c. City, Town or Location   |   | 10d. Inside City Limits<br>1 ☐ Yes 2 🛣 No                               |
|                     | a or 28   | i Director        | 10e. Street and Number 10f. Zip Code 8224 Brandon Drive 21108  | 10  | g. Citizen of What Country? U.S.A.                                      |
| 036                 | be filed within 72 hours after death with the Maryland tal Hygiene. d other then "netural", or iteme 23e or 28e-f ehow event, I're Medical Exer'il ar rrisal ke notified at | by Funerai        | 3 ☐ Widowed 4 ☐ Woivorced Year or Dates:   | Specify Yes or No-<br>to Rican, etc.)         | 14. Race - American Indian,<br>Black, White, etc.<br>Specify: White     |
| Maryland 21215-0036 | within and then a   | Completed         | 15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+) 4  16a. Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired) Accountant                            | rking 1                                       | 6b. Kind of Business/Industry Westinghouse                              |
| land                | should be filed<br>and Mental Hygin<br>marked other<br>imatic event, II   | To Be (           | 17. Father's Name (First, Middle, Last)  18. Mother's Name   | me (First, Middle, M<br>Leola                 |   |
| Mary                | 2 2 2 2   |                   | 19a. Informant's Name/Relationship (Type, Print)  Geoffrey Clingman-son  19b. Mailing Address (Street and Number or Ru 18072 Selkirk Greene  |   |   |
| Baltimore,          | 0 0   |                   | 20a. Method of Disposition  1 DXBurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)  20b. Place of Disposition (Name of cemetery, crematory or other place)  Dulaney Valley  12/  | Date 2<br>/28/05                              | 0c. Location - City or Town, State Timonium, MD                         |
| Baltir              | permit. Pag<br>Department<br>Important::I<br>eny injury o   |                   |  | ck Towson                                     | Funeral Home, Inc.<br>21204   |
|                     | Physician   |                   | 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)               | c or respiratory arre                         | st, Approximate Interval Between onset and Death                        |
| 8760, \$            | Medical Examiner physician and the purial-transit   | dical Examiner    | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of): |   | Days  |
| P.O. Box 6          | The law requires that the death certificate be execute has been signed by the attending physician and age 2 should be detached for use as the burial-tra                    | Physician/Medical | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify)                                |   | 23d. Date of delivery<br>Month Day Year                                 |
|                     | quires that<br>n signed b<br>uld be deta  | ρ                 | Part II. Differ significant conductors contributing to again but not resulting in the underlying cause given in Part I.  | 23e. Did toba                                 | acco use contribute to the cause of death?  s 2 No 3 Probably 4 Unknown |
| of Vital Records,   | The law require<br>ate has been si<br>page 2 should t   | Completed         | . 0  | 24a. Was an autopsy perform                   | prior to completion of cause of   |
| Vita                | Physician: Th<br>r this certificate<br>ral director, pag  | Be                | 25. Was case referred to medical examiner?   | ath (Check only one                           |   |
|                     | Attending Physic death.   | ation: To         | 12 inpatient 2 Envolupatient 3 DOA 4 Nursing h   | 28d. Describe how                             | nce 6 □Other (Specify) v injury occurred                                |
| Division            | al or Attends after death   | Certification:    | 3 Suicide 4 Homicide  6 Could not be determined  28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  | 28f. Location (Str.<br>City or Town,          | eet and Number or Rural Route Number,<br>State)                         |
|                     | To the Hospital or Attending Ph<br>within 24 hours after death.<br>To the Funeral Director: After th<br>completely filled in by the funeral                                 | edicai C          |  | e, and due to the ca<br>urred at the time, da | use(s) and manner as stated.<br>te and place, and due to the cause(s)   |
|                     | To the To the Comp  | M                 | 29b. Signature and title of certifier 29c. License number  |   | d. Date signed (Month, Day, Year)                                       |
|                     |   |                   | runo famica 190 2003272  | +4 i  | ecember 25, 2005  |
|                     | 20+1  |                   | 3D. Name and address of person the completed cause of death (Item 23a) (Type, Print)  MARIA GAVIRIA MD 301 Hoxpital De C   | FLEN B  | mnie Mo 21041   |
| 15                  | Sta<br>Registi  |                   | 31. Date filed (Month, Day, Year) 32. Registrar's Signature  |   |   |

CLINGMAN, Roland

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Yea Physician (LL/AM 1:304 M FCEMBER 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner BALTIMORE 405 SECOURS If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea SEPT 4, 1961 5. Social Security Number 214-78-8563 (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1**X** M 2□ F Hours MARYLAND Director Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits in then "natural", or Items 23a or 28a-f show the Medical Examinar must be motified at MARYLAND BALTIMORE 1 Yes 2 No NA Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1649 N. FULTON AVENUE 21217 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 □XYes 2 □ No If Yes, Give Year or Dates CCT 17, 1985 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. AFRICAN 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: AMERICAN þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) JANITORIAL COMPANY permit. Pages 1 and 2 should be filed wir Department of Health and Mental Hygien Important: If item 27 is marked other tha any nijury or other traumatic event, Ital. Once. MAINTENANCE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) AGNES NEAL JOHN CARTER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) AGNES CARTER MOTHER 1649 N. FULTON AVENUE BALTIMORE, MARYLAND 21217 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State DEC 29, 2005 CATONSVILLE, MARYLAND WESTERN STAR CEMETERY \* 4 Donation 5 Dother (Specify) 22. Name and Address of Facility WYLIE FUNERAL HOME P.A. 21. Signature of Funeral Service Licensee 638 N. GILMOR STREET HALTIMORE, MARYLAND 21217 23 Fart 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) SEPTICEMIA **Physician** /Medical MMUNODEFICIENCY DISORDER Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner physician and s the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, by Physician/Medical the attending I for use as 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year 4 Pregnant at time of death signed by the at id be detached for 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Johnnown Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 2□ No 1 ☐ Yes 212 No 1 🗌 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 → No ٩ 1 Inpatient 2 ER/Outpatient 3 DOA completely filled in by the funeral 28a. Date of Injury (Month, Day 27. Manner de ath 28b Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Estatural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier B 30. Name and address of person who con BON SECOURS (051 32. Registrar's Bionature 31. Date filed (Month, State Registrar

|                     |  |                   | For<br>Stata<br>Registrar  | State                                   | of Mary  | rland / Dep<br><i>Ce</i>               | artmen<br>ertificate                                   |                         |                                       | and M                    | -   | giene<br>Reg. No.       | 005                         | 417                                 | 87                   |
|---------------------|--|-------------------|--|---|--|--|--|-------------------------|---------------------------------------|--------------------------|---|-------------------------|-----------------------------|-------------------------------------|----------------------|
|                     | Physici  | an                | Decedent's Name (First, Middle     Decedent's Name (First, Middle  | e, Last)                                |  |  |  |                         |                                       |                          | 2. Date of De.<br>Month                   | ath<br>Day              | Yea                         | 3. Time o                           | f Death              |
| 1000                | /Medi<br>Examir  | cal               | Delores B. Coates  4a. Facility Name (If not institution  Joseph Richie H  | _                                       | number)  |  |  | Town, or                | Location o                            | of Death                 | December                                  |                         | 2005<br>County of De<br>NA  |                                     | AM                   |
|                     | Funeral<br>Director  |                   | 5. Social Security Number 212–46– 3940   | 6. Sex<br>1 □ M 2 <b>X</b> F            | 7. Age (In   | yrs. last birthday<br>Yrs.             | ) If Under<br>Months                                   | 1 Year<br>Days          | If Under<br>Hours                     | 24 Hrs.<br>Min.          | 8. Date of Bird<br>(Month, Da<br>10-27- 1 | y, Year)                |                             | Birthplace (State of Country) yland | or Foreign           |
|                     | land ow  |                   | Usual Residence of Decedent  10a. State 10b. County  |   | 10   | c. City, Town or I                     | ocation  |                         |                                       |                          |   |                         |                             | 10d. Inside C                       | ity Limits           |
|                     | Mary<br>a-f eh   | tor               | MD N   | A                                       |  | В                                      | altimore   | 5                       |                                       |                          |   |                         |                             | 1 XYes                              | 2 🗆 No               |
|                     | h with the<br>23a or 28a   | ai Director       | 10e. Street and Number<br>4211 Granada Aven  | ue                                      |  |  | 10f. Zip   |                         | 215                                   |                          |   | 10g. Citiz              | en of What (                | Country?                            |                      |
| 980                 | s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Itam 27 is marked other than "natural", or itema 23s or 28s-f show other traumatic event, the Medical Expressional Secretarials. | by Funeral        | 11. Marital Status  1 Never Married 2 Mar 3 Widowed 4 Divorced   | Armed                                   | ecedent Ever<br>Forces?<br>s 24 No<br>Give<br>Dates: | r in U.S. 13                           | Was Deced<br>If Yes, spec                              |                         | spanic Orig<br>n, Mexican<br>Specify: | gin? (Spe<br>i, Puerto l | ecify Yes or No<br>Rican, etc.)           | 1                       | Black, Wi<br>Specify:       | nerican Indian,<br>nite, etc.       |                      |
| Maryland 21215-0036 | within 72 ho<br>ene.<br>than "natu<br>the Medical  | Completed         | 15. Deceder<br>(Specify only higher<br>Elementary/Secondary (0-12)   |   | d)<br>(1-4or 5+)                                     | (Giv<br>life.                          | edent's Usua<br>e kind of wor<br>DO NOT us<br>rsing As | k done o<br>e retired   | luring most<br>)                      | t of workii              | ng  | 16b. Kin                | d of Busines<br>Health      |                                     |                      |
| /land 2             | 2 should be filed<br>and Mental Hygis<br>is marked other<br>aumatic event, I   | To Be C           | 17. Father's Name (First, Middle, Charles Coates   | Last)                                   |  |  |  |                         | 18. Mothe                             |                          | (First, Middle,<br>Outton                 | Maiden S                | Sumame)                     |                                     |                      |
| /an                 | 2 shoul  |                   | 19a. Informant's Name/Relations  |   |  | 1                                      |  |                         |                                       |                          | l Route Numbe                             |                         |                             | , Zip Code)                         | 1                    |
| iore, l             | 0 0  |                   | Darlene Taylor/ Da  20a. Method of Disposition  1 🖾 Buriai 2 🗆 Cremation   | 3 □Removal from                         | m State  | 0b. Place of Disp<br>cemetery, cre     | matory or of   | ne of                   | 3)                                    | D                        | timore, M                                 | 20c. Loc                |                             | or Town, State                      |                      |
| Baltimore,          | permit. Pag<br>Department<br>Important: f<br>any injury o  |                   | 4 Donation 5 Other (S  |   |  |  | 2. Name and  |                         | s of Facility                         |                          |   |                         | alk, MD                     | timore, M                           | n 21217              |
| 8760,0              | Medicale be executed the conflictate be executed and indig physician and as the burial-transit   | ai Examiner       | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. — Due t                              | o (or as a co  | nsequence of):  nsequence of):         |  |                         |                                       |                          |   |                         |                             |                                     |                      |
| .O. Box 6           | death certi<br>e attending<br>id for use a   | Physician/Medical | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 Ø No 9 □ Unknown  |   | birth 2 🗍<br>gnant at time                           | Fetal death 3                          | ⊒Ectopic pre<br>⊒ Other (spe                           |                         |                                       |                          |   | 23                      | 3d. Date of d<br>Month      |                                     | Year                 |
| rds, P              | sign<br>sign<br>d be   | by                | Part II. Other significant condition   | ons contributing to                     | death but no   | t resulting in the                     | underlying ca  | iuse give               | n in Part I.                          |                          | 1   |                         |                             | to the cause of c                   |                      |
| Vital Record        |  | Completed         |  |   |  |  |  |                         |                                       |                          | 24a. Was a autop perfor                   | sy                      | 24b. Were a prior to death? |                                     | available<br>ause of |
| of                  | Attending Physician: Th<br>r death.<br>ector: After this certificate<br>by the funeral director, pag   | tion; To Be       | 25. Was case referred to medica examiner?  1 Yes 2 No  27. Manner of Death  1 Natural 5 Pendir 2 Accident investi  | Hospital: 1 [<br>28a. Dat<br>(Mo        | Inpatient e of Injury onth, Day Yea                  | 2 ER/Outpatie                          |  | Bc. Injury<br>Work      | r: 4 🗆 Nur                            | rsing Hom<br>2           | Check only on the 5 Residuel Rescribe h   | lence 6,                |                             | ecity) Hosp                         | ce                   |
| Division            | al or Attendi<br>s after death.<br>Il Director: A<br>id in by the fu   | Certification;    | 3 Suicide 6 Could 4 Homicide determ  | not be 28e. Pla                         | ce of Injury -<br>ding, etc. (S                      | At home, farm, si<br>pecify)           | reet, factory,   | , office                | 500                                   | 2                        | 8f. Location (S<br>City or Tow            | Street and<br>m, State) | Number or F                 | Rural Route Num                     | ber,                 |
|                     | To the Hospital or Al<br>within 24 hours after of<br>To the Funeral Direct<br>completely filled in by  | edical C          | (Check only 2 Medical  | g Physician: To the<br>Examiner: On the | basis of exa   | y knowledge, dea<br>mination and/or ii | th occurred anvestigation,                             | at the tim-<br>in my op | e, date and<br>inion, deat            | place, a                 | nd due to the o                           | ause(s) a               | nd manner a                 | as stated,<br>ue to the cause(s     | 5)                   |
|                     | To the I within 2. To the I complet  | Med               | one) 29b. Signature and title of certifie  | and ma                                  | inner stated.  |  | 290  | License                 | number                                |                          | 1 :                                       | 29d Date                | signed (Mar                 | oth Day Vaarl                       | 2-per 1, 19          |
|                     | Λ  |                   | 30. Name and address of person   | who completed as                        | use of death   | (item 23a) (Tuca                       | Print  | D                       | 24                                    | 170                      |   | Dece                    | mber                        | 25, 200<br>201                      | 5                    |
| _                   | 7  |                   | E. Tso MD F  | Lichey +                                | ospice   | 838                                    | NEW  | taw                     | St                                    | Bul                      | fimore                                    | M                       | 21                          | 201                                 |                      |
|                     | Sta<br>Registr   |                   | 31. Date filed (Month, Day, Year)  |   | Registrar's S  | Signature                              | gette)   |                         |                                       |                          |   |                         |                             |                                     |                      |

CPM 05-08752 Unpen Please Tupe, pri Print in Black Indekital Thk. Ensure All Copies Are Legible. Walter Dickey State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Rag. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death December 25, 2005 **Physician** KR 22:34 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Bon Secours Hospital Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) OZ · 27 · 19 **Funeral**  Birthplace (State or Foreign Country) Months Hours 1 M 2□ F 251-41-0825 Yrs. Director arolina South Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits ir than "natural", or itama 23a or 28a-f ahow the Medical Examinar must be notified at 1 XYes 2 □ No Director M Baltmore NA 10e. Street and Number 10f. Zip Code 10g. Citizen of Whal Country? 2548 Avenue 21223 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married African -Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced American 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) other then Elementary/Secondary (0-12) College (1-4or 5+) emolition RIVate 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Sumame) Be 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number and Route Number, City or Town, State, Zip Code) AURNU if item 27 i DONLLA Farmer /Wife FREDERICK Md 21223 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State permit. Pege Depertment of Important: if any injury or once. (Jarrison Folest Owings Nills Md 4 □ Donation 5 □ Other (Specify) 12.30.2005 22. Name and Address of Facility 4200 Libecty 21. Signature of Funeral Service Licensee Lie TUNERAL MONS P.H. Of Palrmore County . Enter tile diseas i or complications i at caused the death. Do not enter the mode of dying, such as cardiac or respiratory i rrest, ck, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Subarachnoid Hemorrhage /Medical Due to (or as a consequence of): Examiner Ruptured berry aneurysm Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner attending physicien and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 2 Fetal death in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Cocaine use, Hypertensive cardiovascular disease Completed 1 TYes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an After this certificete has autopsy performed Hospital or Attanding Physician: funeral director. Be 25. Was case referred to medical 26. Place of Death (Chick only one) kaminer? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To XYes 2 No 1 Inpalient 2X ER/Outpation 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 Yes 2 No 2 Accident Diractor: 6 Could not be determined 3 Suicide in by 1 Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide hours ettar within 24 hours e To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. cai (Check only one) 29b. Signature and title of certile 29c. License number 29d. Date signed (Month, Dey, Year) O.C.M.E. December 26, 2005 30. Name and address person who completed cause of death (Item 23a) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201 aippe 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registra

DEC 2 8 2005

**Physician** 

/Medical

Examiner

**Funeral** 

Director

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No... 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 12 2 ay 2 4 2005 10:20a<sup>™</sup> Maria Deleyva 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Wheaton Montgomery Randolph Nursing Home If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Hours 1 ☐ M 2 🔯 F 105 214-04-5584 Columbia, S.A. 12-06-1900 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits MD Montgomery Silver Spring 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20906 USA' 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 21X No If Yes, Give Year or Dates: White XYes 2 No Specify: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Sumame) Maria Josefa Levva 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3802 Belpre Rd. #13 Silver Spring MD 20906 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Gate of Heaven 12/30/2005 Silver Spring, MD 22. Name and Address of Facility
Rapp Funeral & Cremation Service ma1358 933 Gist Av Silver Spring MD 20910 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death apperose Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4□Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2□ No 24a. Was an autopsy performed? 1 Yes 2<del>√</del> № 26. Place of Death (Check only one) Hospital: 1 | Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Injury 1 ☐Yes 2 ☐ No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Descritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as shared.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Suresh Gupta MD 3503 Perry St. Mt. Rainier MD 20712 32. egistrar's Signature 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend item#28a-b, 28e-f, perile, 853,3/30/06 II

State of Maryland / Department of Health and Mental Hygiene George Dieter 05-8630 AG Certificate of Death Reg. No. 2. Date of Death Decedent's Name (First, Middle, Last) 3. Time of Death December 21, Physician GEORGE H. DIETER 10:02A M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore County Franklin Square Hospital Rosedale
If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year)
Oct. 18,1925 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours X1X3 M 2 □ F Yrs. 217~36~4363 Maryland 80 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours atter death with the Maryland nent of Health and Mentat Hygiene. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits in than "natural", or iteme 23a or 28a-f show the Medical Examinan must be notified at Baltimore County 1 ☐ Yes 2 No Baltimore Maryland Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 21237 5069 White Marsh Rd. USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2X No Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 8 yrs. College (1-4or 5+) Self~Employed Farmer N/Alith and Mental Hygid 27 is marked other r traumatic event, in 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Jacob A. Dieter Anna Kraft 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a William J. Dieter, Jr. (Nephew) 5044 White Marsh Rd. Baltimore, Md. 21237 Item 2 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition ō = 5 X1√Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) permit. Page Department of Important: If any Injury or once. St. Joseph Ch. Cem. 12~27~05 Fullerton, Md. 21. Signature of Funeral S 22. Name and Address of Facility Lassahn Funeral Home 7401 Belair Rd. Baltimore, Md. 23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, tmmediate Cause (Final disease or condition resulting in death) **Physician** Due to (or as a consequence of): /Medical Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner inding physicien and use as the burial-transit The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant all time of death 23d. Date of delivery 23b. Was decedent pregnant for L 3 ☐ Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day 5 Other (specify) P.O. sete hes been signed by the page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Vinknown Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No 1 Tyes 2 No Hospitel or Attending Physician: After this certification, funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1XXVes 2 ☐ No Hospital: 1 ☐ Inpatient 2 XXP/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred Injun 1 Natural 5 Pending subject of death. 1 ☐ Yes 2 No 2 Accident 3 Suicide investigation Director: 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) residence 28f. Location (Street and Number or Rural Route Number, ۵ 4 Homicide 1800 Center St. Camp Pring PA hours efter filled in A 24 hou. much Borl 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

\*\*Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check only one) within 2 29c. License number 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 2 O.C.M.E. December 22, 2005 20 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HEODONE M. Ihm 111 Penn Street, Baltimore, Maryland 21201 31. Date filed (Month, Day, Year) 2. Registrar's Signature

DHMH 17 Rev 1/2001

State

Registrar

DEC 2 8 2005

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Month Year **Physician** DIX Nancy 2005 12:22 PM 12 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner College Manor Inc Lutherville Paltimores Count If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1□M 2QF Yrs. Director Jan 16, 1922 | Maryland 216-16-4762 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is merkad other than "natural," or items 23a or 28a-f show any injury or other traumstic avant, the Medical Examinar mater than medical examinar and injury or other traumstic avant, the Medical Examinar mater than a medical examinar and injury or other traumstic avant, the Medical Examinar materials. 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yes 2 ☑ No Director Baltimore Lutherville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 300 W. Seminary Avenue 21093 Funerai USA 12. Was Decedent Ever in U,S. Armed Forces? Was Dacedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☒ No If Yes, Give 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: ģ Specify: white 3 ☑ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 actress entertainment 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Samuel Hunter Norman Ethel S. Suman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nancy Weil/niece 7435 Swanpoint Way Columbia, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 ☐ Other (Specify) 21. Signatur of Funeral Strvice Licensee Ronald S. Wade, 22. Nama and Address of Facility State Anatomy Board 655 W. Baltimore Street 21201 Baltimore, MD Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, owneart failure. List only one cause on each line. **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Aneurysm Rupine Immediani Examiner Due to (or as a consequence of): Examiner signed by the attending physician end id be deteched for use as the buriel-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as a consequence of): Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobecco use contribute to the cause of deeth? 1 ☐ Yes 2XNo 3 ☐ Probably 4 ☐ Unknown ģ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? Emphyse - 1 has 2 No 1 ☐ Yes 2 ☐ No this certificate To the Hospital or Attending Physician: within 24 hours after death. Be ( 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 5 Pending investigation 1 Matural 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours a

To the Funeral D

completely filled i Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sera/75 YURK 1205 31. Date filed (Month, Day, Year) 32. Registrar's Signature State DEC 2 8 2005 Registrar

|            |   |                | 1 - For<br>State<br>Registrer   |  | aryland / Dep<br><i>Ce</i>                               | artment of F<br>rtificate of                           |   |   | jiene<br>1eg. No. 0                 | 5                           | 1792                                      |
|------------|---|----------------|---|--|--|--|---|---|-------------------------------------|-----------------------------|---|
| I          | Physici   | an             | Decedent's Name (First, Middle, Lass     JOSEPH ELLISON   | •  |  |  |   | 2. Date of Dea<br>Month<br>DECEMBE            | Day                                 | Year                        | 3. Time of Death                          |
|            | /Medio<br>Examir  | _              | 4a. Facility Name (If not institution, give   |  |  | 4b. City, Town, o                                      | or Location of De                       |   | 4c. County                          | 005<br>of Death             | 6:45a <sup>M</sup>                        |
|            | LAdilli   |                | 1443 N. FULTON  |  |  | BALTI  | MORE                                    |   | N/                                  | A                           |   |
|            | Funeral   |                | 5. Social Security Number 6. So   | ex 7. Ag<br>MAM 2□F  | e (In yrs. last birthday)                                | If Under 1 Year<br>Months Days                         | If Under 24 H<br>Hours Mi               |   | Year)                               | Coun                        | ace (State or Foreign try)                |
| ш          | Director  | }              | 250-86-1399 Usual Residence of Decedent   |  | 57 Yrs.  |  |   | 3-21-1  | 948                                 | SOUT                        | 'H CAROLINA                               |
|            | show  |                | 10a. State 10b. County  |  | 10c. City, Town or Li                                    | ocation  |   |   |                                     | 10                          | Od. Inside City Limits                    |
|            | e Mar   | ctor           | MD. N/A   |  | BALTIM   | ORE  |   |   |                                     |                             | 1 ☐ Yes 2 ☐ No                            |
|            | with the Maryland<br>is or 28e-f show<br>the notified at  | Director       | 10e. Street and Number  |  |  | 10f. Zip Code  |   |   | log. Citizen of V                   |                             | try?                                      |
|            | death v   |                | 1443 N. FULTON  | AVE .  | Ever in II S 12  | 2121   |   | 10  | USA                                 |                             | 1.0                                       |
| 10         | fter de<br>r Item<br>inerr  | Funeral        | 11. Marital Status 1 ☐ Never Married 2∑ Married   | Amed Forces?   |  | If Yes, specify Cubi                                   | an, Mexican, Pu                         | Specify Yes or No-<br>into Rican, etc.)       |                                     | e - America<br>k, White, e  |   |
| 036        | 72 hours after<br>neturel', or Ite<br>ilcal Exemine   | by             | 3 Widowed 4 Divorced  | If Yes, Give<br>Year or Dates:                                     |  | 1 ☐ Yes 2 🗓 No   | Specify:                                |   | Specify                             | : BLA                       | CK  |
| 21215-0036 | 72 ho   | Completed      | 15. Decedent's Ed<br>(Specify only highest gra  | ucation<br>de completed)   | 16a. Dece  | dent's Usual Occup                                     | pation<br>during most of w              | orkina  | 16b. Kind of Bu                     | usiness/Ind                 | lustry                                    |
| 121        | within<br>sne.<br>than '  | ldm            | Elementary/Secondary (0-12)   | College (1-4or 5   | 1+)  | kind of work done DO NOT use retired                   |   |   | 000                                 |                             |   |
|            | filed v<br>Hygie<br>ther t  |                | -12-<br>17. Father's Name (First, Middle, Last)   | -0-  | FOI  | RM SETTER  |   | ame (First, Middle,                           |                                     | TRUCT                       | ION                                       |
| Maryland   | 2 should be filed withir and Mental Hygiene. Is marked other than sumetic event, the Man  | To Be          | RUFUS ELLISON   |  |  |  | MIN                                     | NIE ELLIS                                     | ON                                  |                             |   |
|            | and 2 sh<br>alth and<br>27 is rr<br>ar treum  |                | 19a. Informant's Name/Relationship (7<br>EVA LEE ELLISO   |  | 19b. Maili<br>144  | ng Address (Street  N. FULT                            | ON AVE.                                 | Rural Route Number<br>BALTIMOR                | r, City or Town, E, MARY            | State, Zip<br>LAND          | Code)<br>21217                            |
| Baltimore, | permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Importent: If them 27 is marked other than "neturel", or Items 23s or 28e-f show eny injury or other treumetic event, the Medical Examiner must be notified at Once. |                | 20a. Method of Disposition  1∑ Burial 2 ☐ Cremation 3 ☐   |  |  | matory or other plac                                   | ' 1                                     |   | 20c. Location -                     | •                           |   |
| altir      | nit. Partme<br>corten<br>injury   |                | 4 □ Donation 5 □ Other (Specify 21. Signature 1 and ral Service Lice)   |  | N D. HIBNE   | MEMORIAL  R Name and Addre                             | ss of Facility P                        | -28-2005 1                                    | INERAL.                             | KE, M<br>HOME               | P.A.                                      |
| m          | Depa<br>Impo<br>eny in  |                | ) math  | ) HB   |  |  |   |   |                                     |                             | LAND 21217                                |
| 4          |   |                | 23a. Part inter the disease, or comp<br>shock, or heart failure. List only  | olications that caused<br>one cause on each lin                    | the death. Do not en                                     | ter the mode of dyin                                   | ng, such as cardi                       | ac or respiratory arr                         | est,                                |                             | Approximate<br>Interval Between           |
|            | Physician   |                | Immedia <sup>W</sup> Cause (Final disease or condition  |  | al Vasco   |  |   |   |                                     |                             | Onset and Death                           |
|            | /Medical<br>Examiner  |                | resulting in death)   |  | a consequence of):                                       |  |   |   |                                     |                             |   |
|            |   | 9              | Sequentially list conditions,   |  | a consequence of):                                       |  |   |   |                                     |                             | 1545S                                     |
| V          | uted<br>d<br>ansit  | Examiner       | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events | ,  |  |  |   |   |                                     |                             |   |
| o          | The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit  | Exa            | resulting in death) Last  | Due to (or as  | a consequence of):                                       |  |   |   |                                     |                             |   |
| 8760,      | ate be  | dlcal          | (   | d  |  |  |   |   |                                     |                             |   |
| 9          | ding p  | 0              | IF FEMALE:  | 23c. If yes, outcome   | of pregnancy   |  |   |   |                                     |                             |   |
| Box        | that the death certific<br>ed by the attending p<br>detached for use as   | Physician/M    | 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No  |  | 2 Fetal death 3  | Ectopic pregnancy Other (specify)                      | ′                                       |   | 23d. Date<br>Mor                    | e of deliver<br>oth [       | y<br>Day Year                             |
| P.O.       | t the c<br>by the<br>achec  | hysi           | 9 Unknown   | 9 Unknown  |  |  |   |   |                                     |                             |   |
|            | res that<br>signed b  | by P           | Part II. Other significant conditions co  | ontributing to death bu  | ut not resulting in the u                                | nderlying cause giv                                    | en in Part I.                           | 23e. Did tot                                  | oacco use contr                     | ibute to the                | cause of death?                           |
| Records,   | w require<br>been si<br>should t  | Completed by   |   |  |  |  |   | 1 □ Ye  | s 2 No                              | 3 Proba                     | bly 4 Dunknown                            |
| ec         | ne taw r<br>has be<br>ge 2 sh   | nple           |   |  |  |  |   | 24a. Was a autops                             | n 24b. V                            | Vere autop                  | sy findings available pletion of cause of |
| <u>E</u>   |   |                |   |  |  |  |   | perform                                       | nea ( a                             | leath?                      | 2 De No                                   |
| Vital      | Physician: Th<br>this certificate<br>ral director, pag  | Be             | 25. Was case referred to medical examiner?  | Hospital:  |  | ot 30 DOA Oth  | OF.                                     | eath (Check only on                           |                                     |                             |   |
| of         | Phys  | . To           | 1 ☐ Yes 2 ☑ No  27. Manner of Death   | 1 ☐ Inpatie<br>28a. Date of Injur<br>(Month, Day                   |  | I JU DON   | 4 Liversing                             | Home 5 Reside                                 |                                     |                             |   |
| ion        | Attending I<br>ir death.<br>ector: After<br>by the funer  | ation          | 1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation   | (Month, Day  | Year) Injury   | Worl   | k?<br>Yes 2 □ No                        |   |                                     |                             |   |
| Division   | r Atte<br>er deg<br>recto<br>by th  | Certification: | 3 ☐ Suicide 6 ☐ Could not be determined   | 28e. Place of Inju   | ury - At home, farm, str                                 | eet, factory, office                                   |   | 28f. Location (St.<br>City or Town            | reet and Numbe                      | er or Rural                 | Route Number,                             |
|            | itel or<br>irs afte<br>rel Dir<br>lled in t   |                |   |  |  |  |   |   |                                     |                             |   |
|            | To the Hospitel or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral  | edical         | 29a. Certifier 1 Certifying Phy<br>(Check only one) 2 Medical Exam  | vsicien: To the best of<br>iner: On the basis of<br>and manner sta | of my knowledge, death<br>examination and/or in-<br>ted. | n occurred at the time<br>vestigation, in my operation | ne, date and place<br>pinion, death occ | e, and due to the ca<br>urred at the time, da | tuse(s) and mar<br>ate and place, a | nner as sta<br>ind due to t | ted.<br>the cause(s)                      |
|            | To ti<br>withii<br>To ti<br>comp  | M              | 29b. Signature and title of certifier   |  |  | 29c. License   | e number                                | 2   | 9d. Date signed                     | (Month, D                   | ay, Year)                                 |
|            | •   |                | Belala &  | enous)   | no   | 200  | 62080                                   |   | 12/                                 | 27/c                        | \ <u></u>                                 |
|            | X   |                | 30. Name and address of person who c  | ompleted cause of de   | eath (Item 23a) (Type,                                   | Print) Pac   | A ST                                    | . Bar   | TO. N                               | 10.                         | 21201                                     |
|            | Sta<br>Registr  |                | 31. Date filed (Month, Day, Year) DEC 2 8 2   | 32. Registra   | r's Signature  | and a  | <u> </u>                                | 0.10  | 10,                                 |                             |   |
| 1          | riegisti  | 7              |   |  | All All  | 1000   |   |   |                                     |                             |   |

State of Maryland / Department of Health and Mental Hygiene 1 - For Stete Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death December 24 **Physician** Margaret Isabel Fuller 2005 7:45 PM /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** St. Elizabeth Nursing Home Baltimore 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Mar. II, 1922 5. Social Security Number 6. Sex 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🕅 F Months Days Hours Min. Baltimore Mar. Yrs. Director 217-14-0913 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10b Counts 28a-f show r items 23a or 28a-f shov dreft ust be notified at 1 ☐ Yes 2 ☐ No Director Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21227 3308 Benson Avenue permit. Pages 1 and 2 should be filed within 72 hours after deeth v. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a any hijury or other traumatic event, the Mudical Exal direct conse. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No Baltimore, Maryland 21215-0036 Specify: White Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Westinghouse Corp. Production Assembler 10 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Anna Nolan Benjamin Taylor 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7052 Melting Shadows Lane, Columbia, MD 21045 Carol A. Turk/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Dec. 29, 2005 Baltimore, Maryland Lorraine Park 21. Signature of Fugeral Service Licens Witzke Funeral Home of Catonsville, Inc. 1630 Edmondson Ave., Catonsville, MD 21228 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final End Stage Dementia Alzheimers Type Physician resulting in death) /Medical Due to (or as a consequence of): Examiner Failure to thrive with Cachexia & anorexia Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner and I-transit The law requires that the death certificate be executed Yrs. Hyphertension resulting in death) Last Due to (or as a consequence of): nding physician a use as the burial-Box 68760, Diabetes type II Yrs. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 4☐ Pregnant at time of death 5 Other (specify) P.O. I 1 ☐ Yes 2 XXNo 9 ☐ Unknown signed b. و ا 23e. Did tobacco use contribute to the cause of death? Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records. Be Completed by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Renal Insufficiency neec 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ▼ No 24a. Was an Immobility Syndrome page 2 s 1 ☐ Yes 2 💢 No Division of Vital Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2X No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) After th funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Injury 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No death. 2 Accident investigation Director: / 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by hours after 4 THomicide 24 hours a 29a. Certifier Kertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Madical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. onel # 100 To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 2 D54749 12-26-2005 30 Name and address of person who completed cause of death (Item 22a (Type, Print) Allen Reilly, MD 801 Toll House Ave. D-1, Frederick, MD 21701 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 2005 8 Registrar

William Fultz 05-08669 crn

| <i>J</i> 00                | 09   |   | For<br>State<br>Registrar  | State of M  | larylan           | •                                | artment<br><i>tificate</i> |                        |                            | and M      | -   | giene                | OOD                       |              | 17  | 94                   |
|----------------------------|--|---|--|---|-------------------|----------------------------------|----------------------------|------------------------|----------------------------|------------|---|----------------------|---------------------------|--------------|---|----------------------|
|                            | Physici  | an  | 1. Decedent's Name (First, Middle, L   | ast)  |                   |                                  |                            |                        |                            |            | 2. Date of De<br>Decemb                     | ath Day              | /2 2 <sup>M</sup>         | <br>የፃና      | 3. Time of 1:35                           | f Death<br>Рм        |
|                            | /Medic<br>Examin   | al  | William Fultz  4a. Facility Name (If not institution, gi Sinai Hospital  | ve street and number  | )                 |                                  |                            | Town, or               | Location o                 |            | Decemb                                      |                      | County of I               |              | 1.55                                      | 1 M                  |
|                            | Funeral<br>Director  |   |  | Sex<br>1 M 2 □ F  | ge (In yrs.<br>77 | last birthday)<br>Yrs.           | If Under<br>Months         | 1 Year<br>Days         | If Under 2<br>Hours        | Min.       | 8. Date of Bir<br>07/23/                    | th<br>1928           |                           | Сои          | place (State of<br>htry)<br>JCKY          | or Foreign           |
|                            | land<br>ow   | -   | Usual Residence of Decedent  10a. State  10b. County   |   | 10c. City         | y, Town or Lo                    | cation                     |                        |                            |            |   |                      |                           | 1            | 0d. Inside C                              | ity Limits           |
|                            | e Mary   | ctor  | Maryland Anne Ar   | undel   | Arno              | old                              |                            |                        |                            |            |   |                      |                           |              | 1 ☐ Yes                                   | 2 <b>X</b> No        |
|                            | with th  | Director  | 10e. Street and Number   | Count   |                   |                                  | 10f. Zip                   |                        |                            |            |   |                      | izen of Wha               |              | -   |                      |
|                            | Jeath<br>The 23  | eral  | 573 Quaker Ridge   | 12. Was Decedent  | t Ever in U.      | .S. 13. \                        | 2101<br>Was Deced          | ent of His             | spanic Orig                | gin? (Spe  | cify Yes or No                              | -                    | ted St                    |              |   |                      |
| 980                        | permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23e or 28e-f show any Injury or other traumatic event, the Medical Examinar must be notified at once.  | by Funeral  | 1 Never Married 2 Married 3 Widowed 4 Divorced   | Armed Forces  1 Yes 2   If Yes, Give Year or Dates:             | ?<br>  No         |                                  | fYes, spec<br>!□Yes 2      | rfy Cubar              | n', Mexican<br>Specity:    | , Puerto F | Ricán, etc.)                                |                      | Black, \                  |              | etc.                                      |                      |
| 2-0                        | 72 ho<br>natur   | eted  | 15. Decedent's E<br>(Specify only highest g.   |   |                   | 16a. Deced<br>(Give              | kind of won                | k done d               | lurina most                | of workin  | ıg  | 16b. Ki              | nd of Busin               |              |   |                      |
| Maryland 21215-0036        | within<br>iene.<br>rthan   | Completed   | Elementary/Secondary (0-12)  | College (1-4or  | 5+)               | Barbei                           | OO NOT us                  | e retired)             | )                          |            |   | Hai                  | ir                        |              |   |                      |
| nd 2                       | al Hyg<br>t other  | BeC   | 17. Father's Name (First, Middle, Las  | t)  |                   | 1                                |                            |                        | 18. Mothe                  | r's Name   | (First, Middle,                             | Maiden               | Sumame)                   |              |   |                      |
| yla                        | J Ment<br>J Ment<br>narkec<br>natic s  |   | Elijah Fultz   |   |                   | 401 14 15                        | · · · · · ·                |                        | Cons                       |            |   |                      |                           |              |   |                      |
| Mai                        | th and the and | 1   | 19a. Informant's Name/Relationship  Caroline Fultz –   | , ,, ,  |                   |                                  | -                          |                        |                            |            | Arnold,                                     | -                    |                           |              |   |                      |
|                            | of Heal  |   | 20a. Method of Disposition   | 70  | 20b. P            | lace of Dispo<br>emetery, cren   |                            |                        | _                          |            | ate   |                      | cation - Cit              |              |   |                      |
| Baltimore,                 | Page<br>iment c<br>tant: If<br>jury or   |   | 1  Burial 2  Cremation 3  4  Donation 5  Other (Spec   | ify)  | 9                 | Stanis                           | slaus                      | Ceme                   | etery                      |            |   |                      |                           |              | Maryla                                    | nd                   |
| Ball                       | Depart<br>Depart<br>Import<br>any In   | 4 Donation 5 Other (Specify)  21. Signature of Funeral Service Idenses  22. Name and Address of Facility David J. Weber 1401 S. Chester 5 |  |   |                   |                                  |                            |                        |                            |            |   |                      | e, M                      | 21           | 231                                       |                      |
|                            |  |   | 23a. Part1. Enter the disease, or shock, or heart failure. List only immediate Cause (Final  |   |                   |                                  |                            |                        |                            |            |   |                      |                           |              | Approximat<br>Interval Bet<br>Onset and I | ween                 |
|                            | Physician /Medical Examiner whysician and priar-transit the priar-transit succession with the priary of the priary | Examiner  | disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Due to (or as  | s a consequ       | uence of):                       | 5 Mr                       | LAC                    | nswe and i                 | Liter      | os der                                      | on c                 | cisc                      |              |   |                      |
| κ 68760,                   | The law requires that the death certificate be executed to has been signed by the attending physicien and bage 2 should be detached for use as the burial-transit  | lical   | IF FEMALE:   | d   |                   |                                  |                            |                        |                            |            |   |                      |                           |              |   |                      |
| P.O. Box                   | the death certifica<br>by the attending pt<br>ached for use as t   | Physician/Med   | 23b. Was decedent pregnant in the past 12 months?  1 ☐ Yes 2 ☐ No 9 ☐ Unknown  | 23c. If yes, outcome 1 Live birth 4 Pregnant a                  | 2 Fetal           | death 3                          | Ectopic pre<br>Other (spe  |                        |                            |            |   | 2                    | 23d. Date of<br>Month     | delive       |   | Year                 |
|                            | w requires that the de<br>been signed by the a<br>should be detached f   | þ   | Part II. Dther significant conditions  Demenha   | contributing to death I   | but not resu      | ulting in the ur                 | nderlying ca               | iuse give              | n in Part I.               |            |   | obacco u<br>Yes 2    |                           |              | ne cause of d<br>ably 4 □l                |                      |
| Division of Vital Records, |  | Completed   |  |   |                   |                                  |                            |                        |                            |            | 24a. Was<br>autor<br>perfo                  |                      | 24b. Wer<br>prior<br>deal | to cor<br>h? | psy findings<br>npletion of c<br>2□ No    | available<br>ause of |
| Vita                       | Physician: The this certificate ral director, pag  | ) Be  | 25. Was case referred to medical examiner? 1 ∠ Yes 2 □ No  | Hospital: 1 X Inpati  |                   | 55/0 1-1                         |                            | Othe                   | -                          |            | (Check only o                               |                      |                           |              |   |                      |
| ion of                     | To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certific completely filled in by the funeral director.   | ation; To   | 27. Manner of Death  1 Natural 5 Pending  2 Accident investigate   | 28a. Date of Inj  | ury<br>ay Year)   | 28b. Time of Injury              |                            | Bc. Injury<br>Work     | 4 🗆 1401                   | 2          | e 5 □ Reside 1<br>8d. Describe 1<br>Subject | now injury           | y occurred                | Specif       | Y)  |                      |
| Divis                      | tal or Atters s after dea al Director ed in by the   | Certification;  | 3 Suicide 6 Could not<br>4 Homicide determined   | 28e. Place of In  |                   | ome, farm, str                   |                            | office                 |                            |            | 8f. Location (S<br>City or Tov              | vn, State,           | )                         |              |   |                      |
|                            | # Hospi<br>24 hou<br># Funer<br>etely fill   | edical  | 29a. Certifier 1 Certifying P (Check only one) 2 Medical Exe   | hysicien: To the best<br>miner: On the basis of<br>and manner s | of examinat       | wledge, death<br>tion and/or inv | occurred a<br>restigation, | t the time<br>in my op | e, date and<br>inion, deat | d place, a | nd due to the<br>d at the time,             | cause(s)<br>date and | and manne<br>place, and   | r as st      | ated.<br>the cause(s                      | i)                   |
|                            | To the<br>within<br>To the   | Me  | 29b. Signature and title of certifier  | 2.75  | )                 |                                  | 29c.                       | License                | number                     |            | I   |                      | e signed (M               |              |   |                      |
|                            | ~ \  |   | > for 2  | sef   | al                | (D)                              |                            | 0.C.                   | M.E.                       |            |   | Dece                 | mber                      | 24,          | 2005                                      |                      |
| j7                         | 10   |   | 30. Name and address of personand Taska Z Gylla  | ben Mil   |                   |                                  |                            | reet                   | ., Bal                     | ltimo      | ore, Ma                                     | ryla                 | nd 21                     | 201          |   |                      |
|                            | Sta<br>Registr   |   | 31. Date filed (Month, Day, Year) DEC 2 8  | B4  | rar's Signa       |                                  | met !                      |                        |                            |            |   |                      |                           |              |   |                      |

05-08615 JODY L GREGG WHM

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

|            |  |                       | Unpend iten Amend Iten 1 - State Registrar   |   | /FIV, 6      | 850, 127<br>Cer                         | 28)0<br>tifica                  | distant                   | ealth a<br>Death                       | nd Me                    |   | giene<br>Reg. <b>N</b> o | 2 1 1 1 500                              |                           | 1795                                   |
|------------|--|-----------------------|--|---|--------------|---|---------------------------------|---------------------------|--|--------------------------|---|--------------------------|--|---------------------------|--|
|            | Physici  | an                    | 1. Decedent's Name (First, Middle, La<br>Jody L. Gregg   | st)   |              |   |                                 |                           |  |                          | 2. Date of De<br>Month                  | Day                      | y Yea                                    | r                         | Time of Death                          |
|            | /Medio   |                       | 4a. Facility Name (If not institution, give  | re street and number  | or)          |   | 4b. City                        | , Town, or                | Location of                            |                          | DECEMB                                  |                          | 0, 200<br>County of De                   |                           | 31 P M                                 |
|            | Exami  | iei                   | SINAI HOSPITAL   |   |              |   | В                               | ALTIN                     | ORE C                                  | ITY                      |   |                          |  | N/A                       | 7                                      |
|            | Funeral<br>Director  |                       | 217-88-5215  | Sex 7. /<br>1 □ X M 2 □ F   | 4 1 4 1      | last birthday)<br>Yrs.                  | If Unde<br>Months               | Days                      | If Under 2<br>Hours                    | Min.                     | B. Date of Bir<br>(Month, Da<br>Oct, 25 | y, Year)                 | 9. 8                                     |                           | State or Foreign<br>1d                 |
| 7          | and and  |                       | Usual Residence of Decedent  10a. State 10b. County  |   | 10c. Ci      | ity, Town or Lo                         | cation                          |                           |  |                          |   |                          |  | 10d. In:                  | side City Limits                       |
| 7          | Ba-f ehc   | Director              |  | N/A   | В            | Baltimo                                 |                                 |                           |  |                          |   |                          |  |                           | Yes 2 No                               |
| 4          | 23a or 2   | ai Dire               | 3909 Dorchest  | er Avenu  | e            |   | 10f. Z                          | p Code                    | 21207                                  |                          |   | 10g. Cit                 | izen of What (                           |                           | J.S.A.                                 |
| 036        | /z nous aner ueam with the maryand<br>natural, or items 23a or 28a-f ebow<br>dical Examinar must be notified at  | by Funeral            | 11. Marital Status  1 ☑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced   | 12. Was Decede<br>Armed Force<br>1 Tyes 25<br>If Yes, Give<br>Year or Date  | s?<br>] No   |   |                                 | edent of Hecrify Cuba     | spanic Orig<br>n, Mexican,<br>Specify: | in? (Spec<br>Puerto R    | ify Yes or No<br>ican, etc.)            | )•                       | 14. Race - Ar<br>Black, Wi<br>Specify: E |                           | ·                                      |
| 21215-0036 | within 72 to<br>iene.<br>then "natu<br>the Medical   | Completed             | 15. Decedent's Elementary/Secondary (0-12)   |   | or 5+)       | life. L                                 | kind of w<br>DO NOT             | ork done d<br>use retired | turina most                            | of working               | g                                       |                          | ind of Busines                           | ·                         |  |
| pu         | should be filed withing the Mental Hygiene.  marked other then imatic event, the Mental Menta | To Be Co              | 9<br>17. Father's Name (First, Middle, Last<br>Howard Gregg  | )   |              | In In                                   | usci                            | all                       |  |                          | (First, Middle,                         | , Maiden                 |  | лоус                      | <u> </u>                               |
| Mary       | of Heath ar  | ľ                     | 19a. Informant's Name/Relationship Howard Gregg  | Type, Print)<br>Father  | •            |   |                                 |                           |  |                          |   |                          | nr Town, State<br>Md 21                  |                           | )                                      |
| Baltimore, |  |                       | 20a. Method of Disposition  1  Burial 2  Cremation 3  4  Donation 5  Other (Speci  | Removal from Sta  | 20b.         | Place of Dispo<br>cemetery, crem        | sition (Na<br>natory or<br>nt ( | ome of other place        | e) 1.                                  | 2/29                     | <b>705</b>                              |                          | ocation - City o                         |                           |  |
| Baltin     | permit. reg<br>Department<br>Important: It<br>any injury o   |                       | 21. Signatur of Funeral Service Lice   |   | ,            | 22                                      | . Name a                        | and Addres                | s of Facility                          | Chai                     | tman-1                                  | Harı                     | ris Fu                                   | nera                      | lHome                                  |
|            | hysician<br>/Medical<br>Examiner   | er                    | 23a. Pol. Enter the disease, or concincok, or hear failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions,   |   | nsive        | Cardiova:<br>quence of):                |                                 |                           |  | cardiac or               | respiratory a                           | rrest,                   |  | Inter                     | oximate<br>val Between<br>et and Death |
| 8760,      | law requires that the usean certificate be executed as been signed by the ettending physicien and 2 should be detached for use as the burial-transit   | Examin                | Sequentially list conditions, If any, leading to immediate cause. Enter Underlying Cause (Disease or injury that infliated events resulting in death) Last   | c.  Due to (or a  |              |   |                                 |                           |  |                          |   |                          |  |                           |  |
| P.O. Box 6 | inal the death certific<br>ed by the ettending pl<br>detached for use as t   | Physician/Medical     | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown   | 23c. If yes, outcon<br>1 \( \subseteq \text{Live birth} \)<br>4 \( \subseteq \text{Pregnant} \)<br>9 \( \subseteq \text{Unknown} \) | 2 ☐ Feta     | al death 3                              | ]Ectopic (                      | oregnancy<br>specify)     |  |                          |   |                          | 23d. Date of o<br>Month                  | delivery<br>Day           | Year                                   |
| rds, P     | w requires mai<br>s been signed t<br>should be det   |                       | Part II. Other significant conditions  Diabetes Mellitus   | contributing to death   | but not re   | sulting in the ur                       | nderlying                       | cause give                | en in Part I.                          |                          |   | obacco (<br>Yes 2        | use contribute<br>□ No 3 □               | to the cau<br>Probably    | se of death?                           |
| œ ;        | ete h  | Completed by          |  |   |              |   |                                 |                           |  |                          |   |                          | prior t                                  | o completion?             | ndings available<br>on of cause of     |
| Vite       | certificete<br>rector, pag   | Be                    | 25. Was case referred to medical examiner?   | Hospital:   | 7.0          |   |                                 | Oth                       |  |                          | (Check only o                           |                          |  |                           |  |
| o u        | Attending Physician: or death. ector: After this certifica by the funeral director,  | ion; To               | 1 X Yes 2 □ No  27. Manner of Death 1 Natural 5 □ Pending  | 28a. Date of li   |              | XER/Outpatien<br>28b. Time of<br>Injury |                                 | 28c. Injun<br>Worl        | / at                                   | 28                       | e 5 🗌 Resi                              |                          | 6 □Other (Sp<br>ry occurred              | oecify)                   |  |
| Divisio    | i i i i i  | edical Certification; | 2 Accident investigation 3 Suicide 4 Homicide 1 Homicide 2 Se. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 286. Place of Injury - At home, farm, street, factory, office City or Town, S |   |              |   |                                 |                           |  |                          |   |                          |  | Rural Roul                | te Number,                             |
| 2          | vithin 24 hours within 24 hours of the Funeral completely filled   | dical                 | 29a. Certifier 1 Certifying P (Check only one) 2 Madical Exa   | hysician: To the be<br>miner: On the basis<br>and manner  | of examin    | owledge, death<br>ation and/or inv      | occurre<br>estigation           | d at the tin              | ne, date and<br>pinion, death          | f place, ar<br>h occurre | nd due to the<br>d at the time,         | cause(s<br>date and      | ) and manner<br>d place, and d           | as stated.<br>ue to the c | ause(s)                                |
| )          | withir<br>To th<br>comp  | ₩.                    | 29b. Signature and title of certifier  | mid   |              |   | 2                               | O C                       | number<br>M E                          |                          |   |                          | te signed (Mo<br>EMBER                   |                           |  |
|            |  |                       | 30. Name and address of person who   | completed cause of  | f death (Ite |   |                                 | ENN S                     | STREET                                 | , BA                     | LTIMOR                                  | Ε, Μ                     | IARYLAN                                  | D, 21                     | .201                                   |
|            | Sta  |                       | 31. Date filed (Month, Day, Year)  |   | strar's Sign | ature /                                 | de                              |                           |  |                          |   |                          |  |                           |  |

|  | ian   | 1. Decedent's Name (First, Middle,  | la O J O J   | 7 G850 12/2  |   |  | 2. Date of D<br>Month   | eath<br>Day  | y Year   | 3. Time of Death   |
|--|---|---|--|--|---|--|---|--|--|--|
| /Medi  | cal   | UP7, 17   | ARIUN  | Marion   |   | and another of Dec   | 12  | 21   | 2005   | 12 A   |
| Examir   | ner   | 4a. Facility Name (If not institution, of   | ealth -  | Beltir   | Bel   | yor Location of Dea  | ith   | 40.  | County of Death<br>Harfor  | 6  |
| Funeral<br>Director  |   | 215~09~0481   |  | e (In yrs. last birthday<br>O Yrs.   | ) If Under 1 Ye<br>Months Day   |  |   | irth<br>(ay, Year)<br>25,19  | 9. Birthplac<br>Country<br>Mary  | ce (State or Fore<br>1)<br>land  |
| MO III   |   | Usual Residence of Decedent  10a. State 10b. County   |  | 10c. City, Town or L   | ocation   |  |   |  | 100  | I. Inside City Lim   |
| fa-f sh  | ctor  | Pennsylvania York   |  | SHREWS   | SBURY   |  |   |  |  | 1 Tyes XX  |
| ms 23a or 28a-i show<br>Fraust be rollied at   | Completed by Funeral Director                       | 313 Luther Drive  | West   |  | 10f. Zip Cod  | 9<br>7361  |   | 10g. Cit   | izen of What Country<br>USA  | y?   |
| Items<br>DEFE  | uner  | 11. Marital Status 1 ☐ Never Married 2 ☐ Married  | 12. Was Decedent<br>Armed Forces?  | Ever in U.S. 13.   | . Was Decedent of<br>If Yes, specify C  | of Hispanic Origin? (<br>Juban, Mexican, Pue   | Specify Yes or N<br>irto Rican, etc.)   | 0-   | 14. Race - American<br>Black, White, etc   |  |
| Exam   | by F  | X Widowed 4 □ Divorced  | If Yes, Give<br>Year or Dates:   | 10   | 1 ☐ Yes 2 🛣 1   | No Specify:  |   |  | Spacify: Whi   | te   |
| "natu<br>edical  | ietec   | 15. Decedent's<br>(Specify only highest   | grade completed)   | (Give  | edent's Usual Oc<br>e kind of work do   | cupation<br>ne during most of wi<br>ired)  | orking  | 16b. K   | ind of Business/Indu   | stry   |
| al Hygiene.<br>I other then "<br>vent, the Me  | omo   | 12 yrs.   | N/A  | 5+)  | Secretar  |  |   | Ste  | wart's De  | pt. Stor   |
| if Health and Mental Hygiene.<br>Item 27 is marked other then "natural", or items 23s or 28s-f show<br>other traumatic event, the Medical Examinar must be notified at | To Be C   | 17. Father's Name (First, Middle, La<br>Fred Meister  | st)  |  |   |  | ame (First, Middle<br>.ian Unkr   |  | Sumame)  |  |
| ls ma  | ľ   | 19a. Informant's Name/Relationship  |  |  |   | eet and Number or F<br>Oak Drive   |   |  | or Town, State, Zip C  | ode)   |
| Health<br>tem 27<br>other tr   |   | 20a. Method of Disposition  | Oaughter)  | 20b. Place of Disp   | osition (Name of  | 1  | Date Date   |  | ocation - City or Town   | n, State   |
| = 5  |   | XX Burial 2 □ Cremation 3<br>4 □ Donation 5 □ Other (Spe  |  | Parkwood   | Cemeter<br>Cemeter  |  | 23-05   | Balt   | imore, Md  |  |
| Department of Hea Important: If Item eny injury or othe once.  |   | 21. 19 a re of Funeral S rivice Lic   | ensee  |  |   | Funeral<br>air Rd. B   |   | Md   | 21236  |  |
| ysician<br>Medical<br>Antial-transit   | ical Examiner                                       | disease or condition resulting in death)  |  | a consequence of):   |   |  |   |  | OX.  | anys   |
| /sicien and<br>e burial-transit  |   | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  | с  | a consequence of):   |   |  |   |  |  |  |
| ding physicien and<br>se as the burial-transit   | icai  | resulting in death) Last  | c. Due to (or as   | a consequence of):   |   |  |   |  |  |  |
| by the attending physicien and ached for use as the burial-transit   | icai  | that inhitited events resulting in death) Last  | c.  Due to (or as d.  23c. If yes, outcome   | a consequence of):  of pregnancy 2    Fetal death 3  | □Ectopic pregna<br>□ Other ( <i>specify</i> ,                                     |  |   |  | 23d. Date of delivery<br>Month Da  | ay Year  |
| gned by the attending pose detached for use as   | Physician/Medical                                   | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 \( \subseteq Yes \)  | c. Due to (or as d. 23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown  | a consequence of):  of pregnancy 2 Fetal death 3time of death 5time  | Other (specify)   | )  |   | tobacco u  |  | cause of death?  |
| te has been signed by the attending page 2 should be detached for use as   | Physician/Medical                                   | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9  Unknown   | c. Due to (or as d. 23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown  | a consequence of):  of pregnancy 2 Fetal death 3time of death 5time  | Other (specify)   | )  | 1 []<br>24a. Wa<br>auto   | tobacco u  | Month Day Use contribute to the No 3 Probab  24b. Were autops prior to comp death?   | cause of death?  |
| te has been signed by the attending page 2 should be detached for use as   | Be Completed by Physician/Medical                   | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown  Part II. Other significant condition:   | c. Due to (or as d. 23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown  | a consequence of):  of pregnancy 2   Fetal death 3  time of death 5   ut not resulting in the incomplete of the second se | Other (specify,   | given in Part I.  26. Place of De  | 24a. Wa auto peri 1 Yes eath (Check only  | Yes 21<br>s an opsy<br>ormed?<br>25 No   | Month Date of the Use contribute to the Value of the Use Contribute to the Value of the Use Contribute of the  | cause of death?  ly 4 Unknow  y findings availal  letion of cause of   |
| certificate has been signed by the attending prector, page 2 should be detached for use as   | To Be Completed by Physician/Medical                | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown  Part II. Other significant condition:   | c. Due to (or as d. 23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown scontributing to death b   | a consequence of):  of pregnancy 2   Fetal death 3  time of death 5  ut not resulting in the in  | ☐ Other (specify, underlying cause  | given in Part I.  26. Place of De  | 24a. Wa auto peri 1 Yes eath (Check only  | tobacco u<br>Yes 21<br>s an oppsy<br>ormed?<br>252 No<br>one)                                  | Month  Dispersion of the Month | cause of death?  |
| certificate has been signed by the attending prector, page 2 should be detached for use as   | To Be Completed by Physician/Medical                | IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1  | Due to (or as  d.  23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown  contributing to death b  live birth 1 Inpatie 28a. Date of Injuice 28e. Place  a consequence of):  of pregnancy 2   Fetal death   5(  itime of death    | Other (specify, underlying cause  ant 3 DOA 28c. Ir                               | given in Part I.  26. Place of De Other: 4 Nursing Illury at Vork?  Yes 2 \( \sum \) No  | 24a. Wa auto per 1   Yes eath (Check only Home 5   Res 28d. Describe  | tobacco u Yes 21 s an ypsy ormed? 25 No one) sidence how injur                                 | Month  Dispersion of the Month Dispersion of the Month Dispersion of the Month Dispersion of the Month Dispersion of the Month Dispersion of Month | cause of death?  Ily 4 Unknow  y findings availa  letion of cause of   |
| certificate has been signed by the attending p<br>rector, page 2 should be detached for use as   | Certification: To Be Completed by Physician/Medical | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown  Part II. Other significant condition: 25. Was case referred to medical examiner? 1  Yes 2 No 27. Manner of Death 1  Natural 5  Pending investigat 2  Accident 3  Suicide 6  Could no determine                | Due to (or as  d.  23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown  s contributing to death b  A Description  28a. Date of Inju (Month, Da  28a. Place of Inju building, et  | of pregnancy 2   Fetal death 3  1 time of death 5  1 time of death 5  2 time of death 5  2 time of death 5  3 time of death 5  4 the sent 2   ER/Outpatie 1 the sent 2   ER/Outpatie 1 the sent 2   Sent Time of Injury 1 the sent | Other (specify, underlying cause  ant 3 DOA of 28c. Ir M 1 treet, factory, office | 26. Place of De Other: 47 Nursing nury at Nork?  Yes 2 □ No  | 24a. Wa auto per 1 yes eath (Check only Home 5 Res 28d. Describe  | tobacco u Yes 2' s an ppsy ormed? 2' No one) iidence how injur (Street an wn, State            | Month  Juse contribute to the Solution of the  | cause of death?  cause of death?  death?  findings availabletion of cause o |
| certificate has been signed by the attending prector, page 2 should be detached for use as   | Certification: To Be Completed by Physician/Medical | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown  Part II. Other significant condition:  25. Was case referred to medical examiner? 1  Yes 2 No 27. Manner of Death 1 Natural 5  Pending investigal 3 Suicide 6 Could no determine  29a. Certifier   Certifying | Due to (or as  d.  23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown  contributing to death b  live birth 1 Inpatie 28a. Date of Injuice 28e. Place  of pregnancy 2 Fetal death 31 time of death 5  ut not resulting in the or sulting in | ont 3 DOA of 28c. Ir  | given in Part I.  26. Place of De Other: 4 Nursing njury at Vork?  Yes 2 No  | 24a. Wa auto per per per per per per per per per per  | tobacco u Yes 2' s an pormed? 2' No one) sidence how injur (Street an wn, State                | Month  Use contribute to the Value contribute to the Value Complete  cause of death?  Ily 4  Unknow  y findings availat letion of cause of  No  Route Number,   |
| te has been signed by the attending page 2 should be detached for use as   | To Be Completed by Physician/Medical                | IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1  | Due to (or as d. 23c. If yes, outcome 1   Live birth 4   Pregnant at 9   Unknown    Hospital: 1   Inpatie 28a. Date of Inju (Month, Da labe 28e. Place of Inju building, et aminer: On the basis o   | a consequence of):  of pregnancy 2   Fetal death   5    it ime of death   5    ut not resulting in the or or or or or or or or or or or or or  | ont 3 DOA and treet, factory, official the occurred at the newstigation, in m     | given in Part I.  26. Place of De Other: 4 Nursing nury at Vork?  Yes 2 No ce et time, date and place by opinion, death occurrence of the property of the prop | 24a. Wa autopen 1 Yes  Path (Check only Home 5 Res  28d. Describe  28f. Location City or Total Cee, and due to the curred at the time | s an ppsy ormed? 2 No one) idence how injur (Street an wn, State a cause(s), date and 29d. Dat | Month  Use contribute to the Value contribute to the Value Complete  cause of death?  ly 4 Unknow y findings availat letion of cause o No  Route Number, let. let cause(s)  |

Cynthia Gladney Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Unpend item#23a.PII 27,28a-f.perME.G850.12-30-05 TT State of Maryland Department of Health and Mental Hygiene 05-08571 MLN Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Year Cynthia Gladney <u>December</u> 19 2005 /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Union Memorial Hospital Baltimore If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1□M 2€ F 49 217-64-5363 Yrs. Director Mar.9,1956 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show the Medical Examiner must be notified at Md. 1√2 Yes 2 □ No Baltimore Direct 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 2111 Greenmount Avenue 21217 USA iteme 23a Funeral Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. l □Yes 2 □ No f Yes, Give Year or Dates: 1 Never Married 2 Married ŏ Baltimore, Maryland 21215-0036 Specify: Black 1 ☐ Yes 2X No δ Specify: 3 ☐ Widowed ♣ Divorced "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) House Keeper Private ofth and Mental Hygid 27 is marked other r traumatic event, II 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Clyde Fenton Smith Sr. Alice Brown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2:
Department of Heelth ar
important: If Item 27 is
any injury or other trau 1933 Eutaw Place, Baltimore, Md. Sheena Smith (Sister) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1√ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 12/27/05 Arbutus, Md. Arbutus Mem.Park 22. Name and Address of Facility

James E. Lincoln F/H PA 21. Signature of Funeral Service Licensee Almy 108 W.North Ave.Baltimore, Md 21201 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician Methadone Intoxication /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examine or Attending Physician: The law requires that the death certificate be executed physicien and the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery atter for u 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 4 Unknown 1 ☐ Yes 2 ☐ No 3 Probably Hypertensive Cardiovascular Disease 24b. Were autopsy findings available prior to completion of cause of death?

1 ☑ Yes 2 ☐ No 24a. Was an autopsy performed? 1 XYes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify မှ 1√Xes 2 No this After thi 28c. Injury at Work? Certification: 27. Manner of Death 28a. Date of Injury 28b. Time of fnd Month, Day Year) fnd Injury 28d. Describe how injury occurred 1 Natural 5 Pending Investigation 1 ☐ Yes 2 No Director: / 2 Accident 12-19-05 4:38 A 6 Could not be determined 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 2111 Greenmount Ave. filled in by within 24 hours after of To the Funeral Direct completely filled in by Found in residence Baltimore, MD 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) allaums OCME December, 20, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day, Year) 32. P Gistrar's S

DEC 2 8 2005

32. P distrar's Signature

111 Penn Street

Baltimore, Maryland 21201

|                          |   |                | 1 - State Amend Item  | State of Ma<br>per SA,                   | aryland / Depa<br><b>g865,03/0</b> 6             | artment of Ho<br>107dbb<br>Tilicate of L       | ealth and M<br>Death                         | lental Hyg                             | giene<br>10g. <b>12</b> .005               | 1,1799                                |
|--------------------------|---|----------------|---|--|--|--|--|--|--|---------------------------------------|
| п                        | G   |                | Decedent's Name (First, Middle, Last)   |  |  |  |  | 2. Date of Dea                         | ith  | 3. Time of Death                      |
|                          | Physici<br>/Medic   |                | Benjamin S. Gold  | berg                                     |  |  |  | Month<br>Decembe                       | r 21, 200                                  |                                       |
|                          | Examin  |                | 4a. Facility Name (If not institution, give                                       |  |  | 4b. City, Town, or                             | Location of Death                            |  | 4c. County of D                            |                                       |
|                          |   |                | Carroll Hospital  | Center                                   |  | Westm:   | inster                                       |  | Carro                                      | 11                                    |
|                          | Funeral   |                | 5. Social Security Number 6. Sex  | 7. Age                                   | e (In yrs. last birthday)                        | If Under 1 Year<br>Months Days                 | If Under 24 Hrs.<br>Hours Min.               | 8. Date of Birth<br>(Month, Day        | ( Year) 9. E                               | Birthplace (State or Foreign Country) |
|                          | Director  |                | 218-18-9682   | ]M 2□F                                   | 91 Yrs.  | Michael Buys                                   |  | Jan 22,                                | . 1914 Ma                                  | ryland                                |
|                          | pug *   |                | Usual Residence of Decedent  10a. State 10b. County                               | -  | 10c. City, Town or Lo                            | cation   |  |  |  | 10d. Inside City Limits               |
|                          | sho   | ō              |   |  |  |  |  |  |  | 1 ☐ Yes 2 ☑ No                        |
|                          | 28a-1   | Director       | MD Carrol1  10e. Street and Number  |  | Sykesv   | 10f. Zip Code                                  |  | ·····                                  | 10g. Citizen of What                       | 71                                    |
|                          | with sa or  |                | 710 Obrecht Road  |  |  |  | 21784  |  | US   | ,                                     |
|                          | ns 23   | Funerai        |   | 12. Was Decedent 8                       | Ever in U.S. 13.1                                | Nas Decedent of His                            |  | cifv Yes or No-                        |  | merican Indian,                       |
| 0                        | r Iter  | Fur            | 1 ☐ Never Married 2 ☐ Married   | Armed Forces? 1 X Yes 2 □ N If Yes, Give | No I   | f Yes, specify Cubar                           | n, Mexican, Puerto                           | Rican, etc.)                           | Black, W                                   | hite, etc.                            |
| 2                        | ral', c   | l by           | 3  Widowed 4 □ Divorced   | If Yes, Give<br>Year or Dates:           | WWII   | 1∐ Yes 2∏ No                                   | Specify:                                     |  | Specify: V                                 | hite                                  |
| ဂ<br>ဂ                   | be filed within 72 hours after death with the Maryland Hygiene. Hygiene. dother than "natural", or items 23a or 28a-f show dother than "natural", or items 23a or 28a-f show event, the Medical Evantral must be notified at  | Completed      | 15. Decedent's Edu<br>(Specify only highest grade                                 |  | 16a, Deced                                       | ient's Usual Occupa<br>kind of work done di    | tion<br>uring most of worki                  | na                                     | 16b. Kind of Busine                        | ss/Industry                           |
| 7                        | ithlo<br>Jen.   | mpi            | Elementary/Secondary (0-12)   | College (1-4or 5                         | i+) life. I                                      | DO NOT use retired)                            |  | 9                                      |  |                                       |
| V                        | led w<br>tygier<br>her ti   |                | 12  | 5+                                       |  | research                                       |  |  | Johns Hop                                  | kins                                  |
|                          | be find he of ot of ot  | Be             | 17. Father's Name (First, Middle, Last)   |  |  |  | 18. Mother's Name                            |  | Maiden Sumame)                             |                                       |
| <u></u>                  | d Mer<br>narke<br>natic   | 1º             | Nathan Goldberg   | na Daint                                 | 405 14-117                                       | . 7445 - (000)                                 |  | Kramer                                 |  | 71.0.11                               |
| Maryland 21215-0036      | d2 st<br>th and<br>7 is n<br>traun  | 6 1            | 19a. Informant's Name/Relationship (Ty) Carroll Hospital                          |  |  |  |  |  | r, City or Town, State                     |                                       |
| ย์                       | permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.  Department of Health and Mental Hygiene.  Department of Health and Mental Hygiene.  Braning or them 27 is marked other than "natural, or thems 23a or 28a-f show any injury or other traumatic event, the Medical Evanting must be notified at ODGe. |                | 20a. Method of Disposition  | -  | 20b. Place of Dispo                              | sition (Name of                                | 1 0  | ate                                    | 20c. Location - City                       |                                       |
| baitimore,               | Pages<br>nent of I<br>ant: If ite<br>ary or o   |                | 1 ☐ Burial 2 ☐ Cremation 3 ☐ R  4 ☑ Donation 5 ☐ Other (Specify)                  | emoval from State                        | cemetery, crer                                   | natory or other place                          | "  |  | ,  | ,                                     |
|                          | artme<br>ortan<br>injur   |                |   | 99 • 2                                   | 22   | . Name and Address                             | s of Facility                                |  |  |                                       |
| ñ                        | Depa<br>Impo<br>any ir  | 9              | 21. Signature of Euneral Service License Ronald                                   | ade vire                                 | ector St   | ate Anato<br>ltimore,                          | my Board                                     | 655 W.                                 | Baltimore                                  | Street                                |
|                          |   |                | 23a. Part1. Enter the disease, or compli  | cations that caused                      | the death. Do not ent                            |  |  |  | est,                                       | Approximate                           |
|                          | Physician   |                | shock, or heart failure. List only or<br>Immediate Cause (Final                   |  | heime-   | Dema   | - fi   |  |  | Interval Between<br>Onset and Death   |
| •                        | /Medical  |                | disease or condition resulting in death)  | 1.                                       | a consequence of):                               | 0 0 0  |  |  |  | 7/3                                   |
|                          | Examiner  |                |   |  | ,          |  |  |  |  |                                       |
|                          | ,   | ner            | Sequentially list conditions, if any leading to introduce cause. Enter Underlying | Due to (or as a                          | а попявоналла оту-                               |  |  |  |  |                                       |
|                          | nd<br>rans  | Examiner       | that initiated events   | ;  |  |  |  |  |  |                                       |
| 8/60,                    | e exe   | Ē              | resulting in death) Last  | Due to (or as a                          | a consequence of):                               |  |  |  |  |                                       |
| 8                        | icate be executed<br>physician and<br>s the burial-transit  | dicai          |   | J  |  |  |  | <del></del>                            |  |                                       |
|                          |   | a)             | IF FEMALE:  | 3c. If yes, outcome                      | of prognancy                                     |  |  |  |  |                                       |
| POX                      | Attending Physician: The law requires that the death certific rideath, redeath, redeath, art death, at each rideath be setter. After this certificate has been signed by the attending by the funeral director, page 2 should be detached for use as  | Physician/M    | in the past 12 months?  | 1 ☐ Live birth 4 ☐ Pregnant at           | 2 ☐ Fetal death 3 ☐                              | Ectopic pregnancy Other (specify)              |  |  | 23d. Date of o                             | delivery<br>Day Year                  |
|                          | the de  | ysic           | 1 ☐ Yes 2 ☐ No<br>9 ☐ Unknown   | 9 Unknown                                | time of death 5                                  | Other (specify)                                |  |  |  |                                       |
| 7                        | res that<br>igned b   | y P            | Part II. Other significant conditions con   | tributing to death bu                    | ut not resulting in the u                        | nderlying cause giver                          | n in Part I.                                 | 23e. Did to                            | bacco use contribute                       | to the cause of death?                |
| gs,                      | quires<br>n sign  | d by           |   |  |  |  |  | 1 🗆 Y                                  | es 2.21% 3 🗆                               | Probably 4 Unknown                    |
| Ö                        | w requir<br>s been si<br>should   | Completed      |   |  |  |  |  | 24a. Was a                             | n 24b. Were                                | autopsy findings available            |
| e<br>L                   | The lay<br>cate has<br>page 2   | omp            |   |  |  |  |  | autops<br>perfori                      | rior t<br>med? prior t<br>death            | o completion of cause of ?            |
| <u>a</u>                 | iclan: Th<br>certificate<br>ector, pag  | a              | 25. Was case referred to medical  |  |  |  | 26. Place of Death                           |  |  | es 2 No                               |
| 2                        | ysiclan:<br>is certific<br>director,  | OB             | examiner?<br>1 ☐ Yes 2 ☑ 1√0  | lospital: 1 Impatie                      | nt 2□ER/Outpatien                                |  |  |  | ence 6 ⊡Othe <i>r (S)</i>                  | pecify)                               |
| DIVISION OF VITAL RECORD | ding Ph<br>h.<br>After th<br>tuneral  | T :u           | 27. Manner of Death 1 ☑ Natural 5 ☐ Pending                                       | 28a. Oate of Injur<br>(Month, Day        | y 28b. Time of                                   | 28c. Injury<br>Work                            | at 2   | 28d. Describe ho                       | ow injury occurred                         |                                       |
| 0                        | endir<br>sath.<br>or: Af<br>he fui  | atic           | 2 Accident investigation  | (,,                                      | injury   |  | es 2 No                                      |  |  |                                       |
|                          | - 0   | Certification: | 3 Suicide 6 Could not be determined   | 28e. Place of Inju-<br>building, etc     | ury - At home, farm, street. (Specify)           | eet, factory, office                           | 2  | 28f. Location (Si<br>City or Town      | reet and Number or<br>n, State)            | Rural Route Number,                   |
| 2                        | To the Hospital or Attenwithin 24 hours after deatl To the Funeral Director: completely filled in by the  |                |   |  |  |  |  |  |  |                                       |
|                          | Hosp<br>24 ho<br>Fune<br>Fune   | edical         | Check only 2 Medical Examir   | ner: On the basis of                     | of my knowledge, death<br>examination and/or inv | occurred at the time<br>restigation, in my opi | e, date and place, a<br>inion, death occurre | and due to the ca<br>ed at the time, d | ause(s) and manner<br>ate and place, and d | as stated.<br>ue to the cause(s)      |
|                          | thin 2<br>the<br>mple   |                |   |  |  |  |  |  |  | nth, Pay, Year)                       |
|                          | E ≥ E 8   |                | Roll J. M.  | 11                                       | in so  |  |  |  |  |                                       |
|                          |   |                | 30. Name and address of person who co   |  | eath (Item 22a) (Tues                            | Print)   |  |  | 2  | 10-1, MI 21135                        |
|                          |   |                | Robert L. Ma  | 21, /                                    | Y Bully  | 41) Ce.  | 1. 6   | Dr. 1                                  | eist 7                                     | 6000, PU 31135                        |
| •. *                     | Sta   | te             | 31. Date filed (Month, Day, Year)   |  | ar's Signature                                   |  |  |  |  |                                       |
| •                        | Registr   | ar             | DEC 2 8 2005  | A Bridge of                              | ar's Signature                                   | SZ.  |  |  |  |                                       |

Amend item#4b-c, per HD, C850, 12/29/05 TT
State of Maryland / Department of Health and Mental Hygique 1 - For Stata Registra Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year Physician December 24, 2005 10:13A Georgia Josephine Goodwin /Medical 4b City, Town or Location of Death 4a. Facility Name (If not institution, give street and number) Prince George's Examiner Montgomery Bethesda Clarington Manor If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Min. Months Days Hours 1 M 2 TF Yrs. 87 March 27, 1918 Virginia Director 577**-**22**-5**488 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State worte ! r than "natural" or Items 23a or 28a-f ehov Tre Medical Exacting must be notified at 1 ☐ Yes 21 No Bethesda Director Maryland Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 4521 East-West Highway #1511 20814 United States death Funeral 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. e filed within 72 hours after at Hygiene.

I Hygiene.

other than "natural", or Itel 1 ☐ Yes 2 🌠 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Black. þ 3 ₩ Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Bureau of Elementary/Secondary (0-12) College (1-4or 5+) Engraving and Printing 12 Inspector 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Importent: If Item 27 is marked oth any injury or other traumatic event size. 17. Father's Name (First, Middle, Last) Be Montgomery James Peters Christine Ball 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Richard M. Goodwin / Son 3311 Gainesville Street, S.E., Washington, D.C. 20020 20b. Place of Disposition (Name of January 20c. Location - City or Town, State 20a. Method of Disposition cemeter, crematory or other place)
Artington
National Cemetery 5, 1 

Burial 2 □ Cremation 3 □ Removal from State 4 Donation 5 Other (Specify) 2005 Arlington, Virginia 22. Name and Address of Facility 21. Signature of Funeral Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue, Bethesda, Maryland 20814 M01420 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 6 Years Breast Cancer /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine physicien and s the burial-transit death certificate be executed Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE: esn 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 ☒ No 3 Ectopic pregnancy Month Year Day ŏ 4☐Pregnant at time of death 5 Other (specify) ed by the a Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Brain Metastases, Liver Metastases Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death? 2□ No 1 Yes 2**X** No 1 Tyes Division of Vital : After this certifical funeral director, I 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4X Nursing Home 5 Residence 6 Other (Specify) 2X No 1 Tes 1 🗌 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification; of or Attending Parties after death.

Director: After it in by the funera 5 Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) To the Hospitel or Atte within 24 hours after de To the Funerel Directo completely filled in by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Madical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier December 27, 2005 DC12568 onor 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Thomas Sacks, M.D. 3301 New Mexico Avenue, N.W., #350, Washington, D.C. 20016 31. Date filed (Month, Day, Year) 32. Rasistrar's Signature State

DHMH 17 Rev 1/2001

Registrar

8 2005

|                     |  |                | For<br>State<br>Registrar  | State of Maryland / Dep  | partment of Health  |  | ene<br>2005 41801  |
|---------------------|--|----------------|--|--|---|--|--|
|                     | Physici  | an             | Decedent's Name (First, Middle, Last)  | C  |   | 2. Date of Death<br>Month                  | Day Year   |
|                     | /Medic   | ai             | Allan N.  4a. Facility Name (If not institution, give s  | Georgetti  | 4b. City, Town, or Location   | December of Death                          | 24, 2005   12:19 a M   |
|                     | Examir   | er             | 11833 Manor Road   | ,  | Glen Arm  |  | Baltimore  |
|                     | Funeral<br>Director  |                | ,  | 7. Age (In yrs. last birthda<br>59 Yrs.  | y) If Under 1 Year If Under Months Days Hours   | March 6,                                   | 9. Birthplace (State or Foreign<br>Country)<br>1946 Pennsylvania           |
|                     | ow ow  |                | Usual Residence of Decedent  10a. State 10b. County  | 10c. City, Town or   | Location  |  | 10d. Inside City Limits  |
|                     | a-f sh   | ctor           | MD Baltim  | nore Glen A  | \rm   |  | 1 Tyes 2 No  |
|                     | or 28  | Director       | 10e. Street and Number   |  | 10f. Zip Code   | 10   | g. Citizen of What Country?  |
|                     | eath v   | eral           | 11.833 Manor Road  |  | 21 057  | rigin? (Specify Yes or No-                 | U.S.A.   |
| 980                 | s within 72 hours after death with the Maryland<br>liene.<br>r than "natural", or flams 23a or 28a-f show<br>the Medical Exactronal be notified at   | by Funeral     | 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced   | Amed Forces?  1 □ Yes 2 □ No If Yes, Give Year or Dates:   | <ol> <li>Was Decedent of Hispanic Of If Yes, specify Cuban, Mexican 1 ☐ Yes 2 ☑ No Specify</li> </ol> |  | Black, White, etc.  Specify: White   |
| 2-0                 | 72 ho  | eted           | 15. Decedent's Educ<br>(Specify only highest grade   | (Cit   | edent's Usual Occupation<br>we kind of work done during mo  | st of working                              | 6b. Kind of Business/Industry  |
| Maryland 21215-0036 | d within<br>giene.<br>r than "   | Completed      | Elementary/Secondary (0-12)  | College (1-4or 5+)   | taurant Dwner/<br>eprenuer  |  | Food   |
| yland               | g ta ta  | To Be          | 17. Father's Name (First, Middle, Last)  Nello   | Georgetti  | Ma  | ner's Name (First, Middle, Ma<br>Bry       | Cerase   |
| Mar                 | 12 shar  |                | 19a. Informant's Name/Relationship (Ty) Victoria L. George   |  | iling Address <i>(Street and Numb</i><br>333 Manor Rd.,   |  | City or Town, State, Zip Code) 21057                                       |
|                     | s 1 and<br>of Heelth<br>Item 27<br>other tr  |                | 20a. Method of Disposition   | 20b. Place of Dis  | position (Name of rematory or other place)  |  | Oc. Location - City or Town, State   |
| <u>m</u>            | Page<br>nent o<br>ant: If<br>ary or  |                | 1X Burial 2 □ Cremation 3 □ R  `4 □ Donation 5 □ Other (Specify)   | emoval from State Dulaney  | Valley  | 12/27/05                                   | Timonium, MD   |
| Baltimore,          | permit. Pages 'Department of H<br>Important: If Ite<br>any injury or of<br>once.   |                | 21. Signature of Funeral Service License   | ⇔ William G. Dau   | 22. Name and Address of Facil   |  | Funeral Home, Inc.<br>21204  |
|                     | Enysician  | 64             | 23a. Part1. Enter the disease, or complications, shock, or heart failure. List only on immediate Cause (Final disease or condition | e cause on each line.  |   |  | Interval Between   |
|                     | /Medical<br>Examiner   |                | resulting in death)  | Due to (or as a consequence of):   |   | Branen                                     |  |
| it                  | ed isit  | Examiner       | Saguration of difference if any, leading to immediate cause. Enter Underlying Cause (Disease or injury                             | Due to (or as a consequence of):   |   | AT-AT-AT-AT-AT-AT-AT-AT-AT-AT-AT-AT-AT-A   |  |
| 8760, ~             | icate be executed physician and the burial-transit   | cal            | that initiated events ' resulting in death) Last   |  |   |  |  |
| .O. Box 6           | law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit | Physiclan/Med  | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown   |  | B □Ectopic pregnancy i □ Other (specify)  |  | 23d. Date of delivery<br>Month Day Year                                    |
| rds, P              | quires that<br>n signed b<br>ıld be deta   | by             | Part II. Other significant conditions con  |  | underlying cause given in Part  | I. 23e. Did toba                           | cco use contribute to the cause of death?  2 > No 3   Probably 4   Unknown |
| Records,            | The law requir<br>ate has been si<br>page 2 should   | ompleted       | A NOTIC GUELLOAUS.   | OTH), POST RNOWL   | MYOCUMUST   | 24a. Was an autopsy performs               |  |
| Vital               | sician: T<br>certificat<br>irector, pa   | O              | 25. Was case referred to medical   |  | 26. Plac  | 1 ☐ Yes 25<br>se of Death (Check only one) |  |
| of V                | y s  | To B           | 1 10S 29 110   | ospital: 1 Inpatient 2 ER/Outpati  | 4 444   | ursing Home 5 Residen                      | ce 6 ☐Other (Specify)  |
| Division o          | ding<br>h.<br>After<br>fune  | atlon;         | 27. Manner of Death  1 Natural 5 Pending 2 Accident investigation  | 28a. Date of Injury<br>(Month, Day Year) 28b. Time<br>Injury   |   | 28d. Describe how                          | injury occurred  |
| Divi                | ital or Attenirs after deat<br>ral Director:<br>led in by the  | Certification; | 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined   | 28e. Place of Injury - At home, farm, building, etc. (Specify)   | street, factory, office   | 28f. Location (Stre<br>City or Town,       | et and Number or Rural Route Number,<br>State)                             |
|                     | To the Hospital or At within 24 hours after or To the Funeral Direct completely filled in by   | ledical        | 29a. Certifier 1 ☐ Certifying Phys (Check only one) 2 ☐ Medical Examin   | sicien: To the best of my knowledge, de<br>ner: On the basis of examination and/or<br>and manner stated. | investigation, in my opinion, de  | ath occurred at the time, dat              | e and place, and due to the cause(s)                                       |
| •                   | To To com  | M              | 29b. Signature and title of certifier  | e mo   | 29c. License number   | 35 1                                       | d. Date signed (Month, Day, Year)  |
|                     | 10   |                | 30. Name and address of person who co<br>ALAN WYITT MD,  | mpleted cause of death (Item 23a) (Type Council House) 23. Projectrar's Signature                        | e, Print) 200 JERNAN OM   | NG BADIMON                                 | , ma, 2/207  |
|                     | Sta<br>Registr   |                | 31. Date filed (Month, Day, Year) 8 2  | 32. Fligistrar's Signature   | Joseph  |  |  |

|                     |   | -                | State of Maryland / Dep   | partment of Health and Nertificate of Death  | ,  | 2.005 41802   |
|---------------------|---|------------------|---|--|--|---|
|                     | Physicia<br>/Medic  | an               | Decedent's Name (First, Middle, Last)     AUGUSTA CARLENIUS HEBRON  |  | 2. Date of Death<br>Month<br>DEC . 23          | 3. Time of Death 11:29P M   |
|                     | Examin  | er               | 4a. Facility Name (If not institution, give street and number) 7518 RIDGE ROAD  | 4b. City, Town, or Location of Death HANOVER   |  | 4c. County of Death ANNE ARUNDEL  |
|                     | Funeral<br>Director   |                  | 5. Social Security Number  220-22-0869  6. Sex 1 M 2 M F  7. Age (In yrs. last birthday 82 Yrs.  Usuaf Residence of Decedent  | Months Days Hours Min.   | 8. Date of Birth<br>(Month, Day, Ye<br>06/24/1 | 9 2 3 9. Birthplace (State or Foreign Country) MARYLAND                                     |
|                     | Maryland -f show  | tor              | 10a. State 10b. County 10c. City, Town or I ANNE ARUNDEL HANOV  |  | 1, 4   | 10d. Inside City Limits<br>1 ☐ Yes <b>≵CX</b> io  |
|                     | ith the   | Funeral Director | 10e. Street and Number  | 10f. Zip Code  | 10g.   | Citizen of What Country?  |
|                     | sath w  | eral             | 7518 RIDGE ROAD  11 Marital Status 12. Was Decedent Ever in U.S. 13   | 21076  | pecify Ves or No.                              | USA  14. Race - American Indian,  |
| 920                 | in 72 hours after death with the Maryland "natural, or items 23a or 28e-f show leatest Exaculter cast be notified at  | þ                | 11. Marital Status  1 Never Married Americal Amed Forces?  1 Never Married Americal Amed Forces?  1 Yes 2 Note of the status of | Was Decedent of Hispanic Origin? (Spif Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 ♥ No Specify:     | o Rican, etc.)                                 | Black, White, etc.  Specify: BLACK  |
| Maryland 21215-0036 | c _ @   | Completed        | (Specify only highest grade completed) (Giv<br>Elementary/Secondary (0-12) Coflege (1-4or 5+)   | edent's Usual Occupation<br>e kind of work done during most of work<br>DO NOT use retired)<br>OMEMAKER | king   | . Kind of Business/Industry  DOMESTIC   |
| d 21                | filed<br>Hygi<br>ther<br>int, I   | o l              | 8TH  17. Father's Name (First, Middle, Last)  |  | ne (First, Middle, Maid                        |   |
| ylan                | 2 should be and Mental Is marked o  | To B             | FRANK SEWELL  |  | VER  |   |
| Mar                 | 교육 22 분 명   |                  |   |  | ty or Town, State, Zip Code) MD 21076          |   |
| ore,                | iges 1 ar<br>it of Hea<br>it item<br>or othe  |                  |   | ematory or other place)  |  | Location - City or Town, State  |
| Baltimore,          | permit. Pages Department of I Important: If Ite any injury or of  |                  | `4 □Donation 5 □Other (Specify) ST. RE  | ST CEMETERY 12/  |  | IANOVER, MD INERAL HOME 21207   |
| Ba                  | Depart impo   |                  | Coment Emy or   | 4600 LIBERTY HE  | GIGHTS AV                                      | E., BALTIMORE, MD   |
|                     |   |                  | 23a. Part 1. Enter the disease, or complications that caused the death. Do not e shock, or heart failure. List only one cause on each fine. Immediate Cause (Final  |  |  | Approximate<br>Interval Between<br>Onset and Death  |
|                     | Physician<br>/Medical   |                  | disease or condition resulting in death)  Due to (or as a consequence of):  | BITNAL PAI   | L UNIE   | 10425   |
| L                   | Examiner  | 6                | Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):  | 100  |  | 30411   |
|                     | nd<br>ransit  | Examine          | causé. Enter Underlying<br>Cause (Disease or injury<br>that initiated events c.   |  |  |   |
| 8760,               | be executed<br>sician and<br>burial-transit   | dical Ex         | Due to (or as a consequence of):  |  |  |   |
| 9                   | ng physical of as the b   | Medic            | IF FEMALE:  |  |  |   |
| O. Box              | that the death certificate be executed<br>the by the attending physician and<br>detached for use as the bunal-transit | Physician/Me     | 23b. Was decedent pregnant  1 Live birth 2 Fetal death 3  | □Ectopic pregnancy □ Other (specify)   |  | 23d. Date of defivery  Month Day Year   |
| rds, P              | law requires that the as been signed by the 2 should be detache   | by               | Part II. Other significent conditions contributing to death but not resulting in the  | underlying cause given in Part I.  | 23e. Did tobacc                                | co use contribute to the cause of death?  |
| Vital Records,      | The<br>ate h<br>page  | Completed        |   |  | 24a. Was an autopsy performed                  | 24b. Were autopsy findings available prior to completion of cause of death?  1 □ Yes 2 □ No |
| Vita                | Physician: Th<br>this certificate<br>ral director, pag  | Be               | 25. Was case referred to medical examiner?  | Other  | tn (Check only one)                            |   |
| of                  |   | on: To           | 27. Manner of Death 28a. Date of Injury 22b. Time   | of 28c. Injury at  | 28d. Describe how in                           | e 6 □Other (Specify)<br>nitury occurred   |
| Division            | at Series   | Certification:   | 2 Accident investigation 3 Suicide 6 Could not be   | M 1 Yes 2 No   | 28f. Location (Street                          | t and Number or Rural Route Number,   |
| Ο̈́                 | ital or Att<br>rs after de<br>rei Directo   | Certii           | 4 Homicide determined building, etc. (Specify)  | ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,  | City or Town, St                               | ate)  |
|                     | To the Hospital or Attu<br>within 24 hours after de<br>To the Funerel Direct<br>completely filled in by th            | edical           | 29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, de- 2 Medicel Exeminer: On the basis of examination and/or and manner stated.   |  |  |   |
|                     | To th<br>withir<br>To th<br>comp  | Ň                | 29b. Signature and title of certifier   | 29c. License number  |  | Date signed (Month, Day, Year)  |
| 7                   | 0   |                  | 30. Name and address of person who compfeted cause of death (Item 23a) (Type  | e, Print)  |  | 21091   |
|                     | 7   |                  |   |  |  | , _ , ,   |
|                     | Sta   | 10               | 31. Date filed (Month, Day, Year)  DEC 2 8 2005   | HUMIN GOM  | ), LINIS                                       | ים מין רעון אר  |

Registrar

 $A \cdot M$ 

2005

28,

DECEMBER

BETTY

HEFRIGHT,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend item#5, periff., (851,1/12/06 TT

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician **GEORGE** J. HOOPER 0610 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner UPPER CHESAPEAKE MEDICAL CENTER BEL AIR HARFORD 5. Social Security Number 4101 6. Sex 7. Age (In yrs. last birthday) | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 1-29-1925 9. Birthplace (State or Foreign **Funeral** 219-18-4103 Director MARYLAND Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location r then "natural", or items 23a or 28a-1 show the Madical Exeminer must be notified at 10d. Inside City Limits MD BALTIMORE ROSEDALE 1 ☐ Yes 2 X No Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1210 BERKWOOD ROAD 21237 U.S.A. 12. Was Decedent Ever in U.S.
Armed Forces?
14∑Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No þ If Yes, Give Year or Dates: 1943–46 Specify Specify: 3 Widowed 4 Divorced WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12 College (1-4or 5+) QUALITY CONTROL MARTINS 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) DIXON HOOPER CELESTE UNKNOWN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LINDA BRAITHWAITE/ DAUGHTER 2704 GOLF COURT BALTIMORE, MD 21013 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 5 Burial 2 Cremation 3 Removal from State permit. Page
Department o
Importent: If
eny Injury or
once. 4 ☐ Donation 5 ☐ Other (Specify) GARDENS OF FAITH CEM 12-30-05 BALTIMORE, MD 21. Signature of Euneral Service Licensee 22. Name and Address of Facility CVACH/ROSEDALE FUNERAL HOME 1211 CHESACO AVENUE ROSEDALE. MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Endo Carditis **Physician** /Medical Due to (or as a consequence of): Examiner Septicemia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Gran Negative.

Due to (or as a consequence of): Gran Infection in past 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4 □ Pregnant at time of death Year 5 Other (specify) Ö 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, δ deep ucin Thrombosis 1 ☐ Yes 2 SHO 3 ☐ Probably 4 ☐ Unknown Alvin Aboillahing 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? Demouria 1 ☐ Yes 2 ☐ No 1 Yes Vital 2 **N**O 25. Was case referred to medical examiner? Certification: To Be 26. Place of Death (Check only one) Hospital: 1 ☐ Impatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🖼 🗸 🗸 Division of 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Matural 5 Pending М 1 ☐ Yes 2 ☐ No 2 Accident investigation MA after death completely filled in by the 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Momicide To the Hospitel o within 24 hours aft To the Funerel DII 29a. Certifier 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier K. Desai, MD 29d. Date signed (Month, Day, Year) D0062704 12. 27. 2005 Bel Air, MD 21014 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Chesapenke Health, 500 KARTIK DEINI, MD Upper 32. Registrar's Signature 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

State

Registrar

8 2005

tooper

|                     |   |                  | For<br>State<br>Registrar   | State of Ma  |                          | epartment o<br>Certificate d                       |  | d Mental Hyg                                    | pieme 005                                      | 41805  |
|---------------------|---|------------------|---|--|--------------------------|--|--|---|--|--|
| *                   | A.5   |                  | 1. Decedent's Name (First, Middle, Las  | it)  |                          | -  |  | 2. Date of Dea<br>Month                         | th   | 3. Time of Death                                 |
|                     | Physici<br>/Medic   |                  | Wanda Marcelin  | e Harney   |                          |  |  | December  | Day 2005                                       | 10:27 P <sup>M</sup>                             |
|                     | Examin  | er               | 4a. Facility Name (If not institution, give   |  |                          |  | n, or Location of De                         | eath  | 4c. County of Dea                              |  |
|                     |   |                  | Frederick Villa   |  |                          | Catons   |  |   | Baltimor                                       |  |
| ŧ.                  | Funeral<br>Director   |                  | 204-12-4104   | ox 7. Age □ M 2(X) F 9.  | (In yrs. last birti<br>2 | nday) If Under 1 Yours. Months Da                  |  | Irs. 8. Date of Birth (Month, Day Nov. 10       | (Year) C                                       | rthplace (State or Foreign<br>ountry)<br>010     |
|                     | and<br>W  |                  | Usual Residence of Decedent  10a. State 10b. County   |  | 10c. City, Town          | or Location  |  |   |  | 10d. Inside City Limits                          |
|                     | Maryl<br>fehc   | ō                | Maryland Baltimo  |  | Catons                   |  |  |   |  | 1 ☐ Yes 2 🛣 No                                   |
|                     | 288-  | rec              | 10e. Street and Number  |  |                          | 10f. Zip Cod                                       | le   | 1   | log. Citizen of What C                         | ountry?  |
|                     | h with  | Funeral Director | 711 Academy Road  |  |                          | 21228  | 3  |   | USA  |  |
|                     | deatl   | ner              | 11. Marital Status  | 12. Was Decedent Example Forces?   | ver in U.S.              |  |  | (Specify Yes or No-<br>erto Rican, etc.)        | 14. Race - Am                                  |  |
| Maryland 21215-0036 | within 72 hours after death with the Maryland<br>ene.<br>then "natural", or Items 23a or 28a-f ehow<br>the Madical Exam nat must be notified at   | by               | 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced  | 1 Yes 2 No<br>If Yes, Give<br>Year or Dates:                                     |                          | 1 ☐ Yes 2X   |  | eno Rican, etc.)                                | Black, Whi                                     |  |
| Ö                   | 72 ho   | ted              | 15. Decedent's Ed<br>(Specify only highest grad   |  | 16a.                     | Decedent's Usual Oc<br>Give kind of work do        | cupation                                     | un della a                                      | 16b. Kind of Business                          | /Industry  |
| 2                   | ithin 7.  | Completed        | Elementary/Secondary (0-12)   | College (1-4or 5+  | )                        | life. DO NOT use re                                | tired)                                       |   |  |  |
| 2                   | lled w<br>tygier<br>her th  | ပိ               | 17. Father's Name (First, Middle, Last)   |  | C1                       | erk  | 140 141 14 14                                |   | Social Secu                                    | ırity  |
| auc                 | d be findal Head of   | Be c             | Leo Karasiewicz   |  |                          |  |  | lame <i>(First, Middle, I</i><br>es Jankows     |  |  |
| 2                   | shoute<br>od Me<br>mark<br>mark   | ဥ                | 19a. Informant's Name/Relationship (7   | voe. Print)  | 19b.                     | Mailing Address (Str                               |  |   | City or Town, State,                           | Zin Codol  |
| ¥<br>Ma             | and 2 a<br>salth ar<br>n 27 io<br>ior trau  |                  | Joann M. Olchowsk   |  |                          |  |  | Ellicott  |  | 21042  |
| altimore,           | permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importment of Health and Mental Hygiene. Instructive of Health and Mental Hygiene. environment: if item 27 is marked other than "natural", or item as 23 a or 28a-f show envirolant; if item 27 is marked event, the Madical Examination at the notified at once. |                  | 20a. Method of Disposition  1 Depurial 2 Cremation 3 4 Donation 5 Other (Specify                            |  | Woodlay                  | Disposition (Name of crematory or other on Cemete) |  | Date 28 2005                                    | 20c. Location - City or<br>Baltimore           | Town, State<br>MD                                |
| Balt                | permit. Departr Importe eny inji  |                  | 21. Signature of Foperal Service Licent   |  |                          | 22. Name and Ac<br>Witzke I                        | dress of Facility<br>Funeral Ho              | ome of Cat                                      | consville,                                     | Inc.   |
|                     |   |                  | 23a. Part1. Enter the disease, arcomp<br>shock, or heart failure. List only                                 | olications that caused t   | he death. Do n           | ot enter the mode of                               | dying, such as card                          | iac or respiratory arre                         | est,   | Approximate<br>Interval Between                  |
|                     | Physician   |                  | Immediate Cause (Final disease or condition   | . Duod   | 9 200                    | Con  | Cinome                                       |   |  | Onset and Death                                  |
| Profit.             | /Medical  |                  | resutting in death)   | Due to (or as a  | consequence o            |  | Cinoma                                       |   |  | 6 months   |
|                     | Examiner  |                  | Sequentially list conditions,   | b  |                          |  |  |   |  |  |
|                     | ed<br>sit   | nine             | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | Due to (or as a  | consequence o            | ):   |  |   |  |  |
|                     | al-tran   | Examiner         | that initiated events resulting in death) Last  | c. Due to (or as a   | consequence o            | ):   |  |   |  |  |
| 68760,              | ficate be executed<br>physician and<br>is the burial-transit  | edicai E         | l   | d  |                          |  |  |   |  |  |
| _                   |   | edi              |   |  |                          |  |  |   |  |  |
| D. Box              | The law requires that the death certif<br>te has been signed by the ettending<br>page 2 should be detached for use as   | Physician/M      | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown                     | 23c. If yes, outcome of<br>1 □ Live birth 2<br>4 □ Pregnant at ti<br>9 □ Unknown | Fetal death              | 3 ☐ Ectopic pregna<br>5 ☐ Other (specify           |  |   | 23d. Date of de<br>Month                       | livery<br>Day Year                               |
| P.0                 | hat thed by   | P.               | Part II. Other significant conditions co  | entabuting to death but  | not resulting in         | he underlying cause                                | gwon in Part I                               | 22a Did toh                                     | pacco use contribute to                        | the sauce of death?                              |
| Vital Records,      | w requires that the de<br>been signed by the c<br>should be detached  | ted by           | Deme  |  |                          | underlying cause                                   | given in ranti.                              |   |  | obably 4 Unknown                                 |
| ecc                 | law ri<br>las be  | Completed        |   |  |                          |  |  | 24a. Was ar                                     | n 24b. Were ai                                 | utopsy findings available completion of cause of |
| <u> </u>            |   | Con              |   |  |                          |  |  | perforn   | ned?   death?                                  | 2 No   |
| Vita                | iclan<br>Sertifi<br>ector   | Be               | 25. Was case referred to medical examiner?  | Hasaitali  |                          |  | 0.1  | eath (Check only one                            |  |  |
|                     | Physical dir  | ٦.               | 1 Yes 2 No  |  | 2 ER/Out                 | ALIBITE 3 DOA                                      |  |   | nce 6 Other (Spe                               | city)  |
| O                   | ding Phy  | tion             | 1 Accident 5 Pending 2 Accident investigation   | 28a. Date of Injury<br>(Month, Day   | Year) 28b. Ti            |  | njuryat<br>Work?<br>☐ Yes 2 ☐ No             | 28d. Describe ho                                | w injury occurred                              |  |
| Division of         | i or Attending Physician:<br>effer death.<br>Director: After this certifica<br>in by the funeral director, i  | Certification:   | 3 Suicide 6 Could not be determined   | 28e. Place of Injur  | y - At home, farr        | n, street, factory, offi                           |  | 28f. Location (Str                              | reet and Number or Ri                          | ural Route Number,                               |
| ā                   | urs efter<br>real Dia   |                  |   | building, etc.   |                          |  |  | City or Town                                    |  |  |
|                     | To the Hospital or Al<br>within 24 hours efter of<br>To the Funeral Direc<br>completely filled in by  | edical           | 29a. Certifier (Check only one)  1 Certifying Phy 2 Medical Exem  | rsician: To the best of<br>iner: On the basis of e<br>and manner state           | xamination and           | death occurred at the<br>or investigation, in m    | e time, date and pla<br>ny opinion, death oc | ce, and due to the ca<br>curred at the time, da | use(s) and manner as<br>ate and place, and due | stated.<br>to the cause(s)                       |
|                     | To T<br>To t  | Σ                | 29b. Signature and title of certifier   | 1/6  | 1                        | 29c. Lic   | ense number                                  | 29  | od. Date signed (Mont                          | /  |
|                     | O   |                  | I Show /  | he Con   | 200                      | T.   | 3876   | -   | 12/2   | 4/05   |
| 6                   |   |                  | 30. Name and address of person who c  | I. Mc C  | 20021                    | c 1  | 411 010<br>altimo                            |   | . 2/229  | 7  |
|                     | Sta<br>Registr  |                  | 31. Date filed (Month, Day, Year) DEC 2 8 20  | 32. Filgistrar   | s Signatur               | Book   |  |   |  |  |

|          |   |                | State RegistraAmend item  |  |   | partment of H   |   |                                  | iene<br>0 0 5                     | 41806  |  |  |
|----------|---|----------------|---|--|---|---|---|----------------------------------|-----------------------------------|--|--|--|
|          |   |                | Decedent's Name (First, Middle, La  | ast)   | 3831_1/ <i>3</i> 1  | 706 JH  |   | 2. Date of Deat<br>Month         |                                   | 3. Time of Death                                       |  |  |
|          | Physicia<br>/Medic  |                | Miriam S. Hutton  |  |   |   |   | 12                               | 27 2005                           | 06:30&   |  |  |
|          | Examin  | er             | 4a. Facility Name ( <i>If not institution, gi</i><br>8615 Woodbrook 1   |  |   |   | Chase   |                                  | 4c. County of E                   | Death<br>Gomery  |  |  |
|          | Funeral   |                | 5. Sec 7 Sec 0 NG 27 6.   | Sex 7. Age   | (In yrs. last birthd  | ay) If Under 1 Year   | If Under 24 Hrs.  | 8. Date of Birth<br>(Month, Day, |                                   | Birthplace (State or Foreign Country)                  |  |  |
|          | Director  |                | 35 <del>7 26 7854</del>   | 1□M 20\$F 8  | O Yrs   | Months Days   | Hours Min.  | 07-06-1                          |                                   | ashington DC   |  |  |
|          | and   |                | Usual Residence of Decedent  10a. State 10b. County   |  | 10c. City, Town or  | Location  |   |                                  |                                   | 10d. Inside City Limits                                |  |  |
|          | Maryl<br>f sho  | tor            | MD Monts  | gomery   | Chevy   | Chase   |   |                                  |                                   | 1 ☐ Yes 2 🗷 No   |  |  |
|          | h the   | Director       | 10e. Street and Number  |  |   | 10f. Zip Code   |   | 1                                | 0g. Citizen of Wha                | t Country?   |  |  |
|          | 23a c   | aiD            | 8615 Woodbrook  | Lane   |   |   | 20815   |                                  | USA                               |  |  |  |
| 020      | s 1 and 2 should be filed within 72 hours after death with the Maryland f Heatth and Mental Hygiene. Item 27 te marked other than "natural", or Items 23a or 23e-f show other traumatic event, the Medical Exemples must be notified at | by Funerai     | 11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☑ Widowed 4 ☐ Divorced   | 12. Was Decedent E<br>Armed Forces?<br>1 ☐ Yes 2 ☒ N<br>If Yes, Give<br>Year or Dates: |   | 3. Was Decedent of H If Yes, specify Cuba  1 ☐ Yes 2 ☑ No     | ispanic Origin? (Spe<br>an, Mexican, Puerto<br>Specify: | ecify Yes or No-<br>Rican, etc.) |                                   | American Indian,<br>Vhite, etc.<br>hite                |  |  |
| ה<br>ה   | 72 ho<br>natur  | eted           | 15. Decedent's E<br>(Specify only highest gi  |  | (G  | cedent's Usual Occup-<br>ive kind of work done                | during most of work                                     | ing                              | 16b. Kind of Busine               | ess/Industry   |  |  |
| 7        | within  | Completed      | Elementary/Secondary (0-12)   | College (1-4or 5-<br>2+  | +) /if  | e. DO NOT use retired   | 1)  |                                  | Congres                           | sman's Office  |  |  |
| 7 5      | filed v<br>Hygie<br>other i   | ပ္ပ            | 17. Father's Name (First, Middle, Las   |  | EX  | ecutive Sec   | 18. Mother's Name                                       | e (First, Middle, I              |                                   | Omaii o office   |  |  |
|          | should be filed within nd Mental Hygiene. marked other than amatic event, ILO M.  | To B           | Phillip Stearns   |  |   |   | Sarah S   | uplinsky                         | ,                                 |  |  |  |
| Mary     | and 2 should be<br>lealth and Mental<br>m 27 ta marked o<br>her traumatic eve   |                | 19a. Informant's Name/Relationship<br>Glen R. Hutton/s  |  |   | ailing Address <i>(Street a</i>                               |   |                                  |                                   | te, Zip Code)  |  |  |
| more     | permit. Pages 1 an<br>Department of Heal<br>Important: If Item 2<br>any Injury or other<br>once.  |                | 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ 1 ☐ Donation 5 ☐ Other (Spec  |  | cemetery, o   | sposition (Name of<br>crematory or other place<br>eake Cremat | e)  | 28-2005                          | 20c. Location - City<br>Beltsvi   |  |  |  |
| Dallimor | permit. Departrimporta any Inju   |                | 21. Signature of Funeral Service Lice   |  | 91358   | 22. Name and Address Rapp Fund                                | eral & Cre<br>Av Silve                                  | emation<br>r Spring              | Service                           | n  |  |  |
|          | Physician   |                | 23a. Part1. Enter the disease, or cor<br>shock, or heart failure. List only<br>Immediate Cause (Final<br>disease or condition     |  |   | enter the mode of dyin  |   | or respiratory arm               | est,                              | Approximate Interval Between Onset and Death U.P.O.K.S |  |  |
|          | /Medical<br>Examiner  |                | resulting in death)   | Due to (or as a  | consequence of):  |   |   | 7                                |                                   |  |  |  |
|          | uted<br>d<br>anslt  | Examiner       | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events | Due to (or as a  | consequence of):  |   |   |                                  |                                   |  |  |  |
| 28/00,   | iicate be executed<br>physician and<br>s the burial-transit   | edical Ex      | resulting in death) Last  | Due to (or as a  | consequence of):  |   |   |                                  |                                   |  |  |  |
| _        | .Ξ O α  | Med            | IF FEMALE:  | ~  |   |   |   |                                  |                                   |  |  |  |
| .c. Box  | w requires that the death certifi<br>been signed by the attending<br>should be detached for use as  | Physician/Me   | 23b. Was decedent pregnant in the past 12 months?  1 □ Yes 2 ☒ No 9 □ Unknown   | 23c. If yes, outcome of 1 Live birth 2 4 Pregnant at 1 9 Unknown                       | 2 ☐ Fetal death   | 3 Ectopic pregnancy 5 Other (specify)                         |   |                                  | 23d. Date of<br>Month             | delivery<br>Day Year                                   |  |  |
| cords, r | requires that the<br>leen signed by th<br>hould be detache  | eted by P      | Part II. Other significant conditions   | contributing to death bu   | t not resulting in th   | e underlying cause give                                       | en in Part I.   | 23e. Did tob                     | 1                                 | e to the cause of death?  Probably 4 Unknown           |  |  |
| T<br>T   | The lay<br>ate has<br>page 2  | Complet        |   |  |   |   |   | 24a. Was a autops perform        | y prior                           |  |  |  |
| VII      | Physician:<br>rthis certific<br>ral director,   | Be             | 25. Was case referred to medical examiner?  | Hospital:  |   | aines actions Other   | 26. Place of Death                                      |                                  |                                   | ,  |  |  |
| 0        | Phys<br>this<br>al di   | n: To          | 1 Yes 2 No 27. Manner of Death  | 28a. Date of Injun<br>(Month, Day  | y 28b. Tim  | e of 28c. Injury  | 4   Nursing no  | me 5 Aeside<br>28d. Describe ho  | ence 6 Other (Sow injury occurred | Specify)   |  |  |
| Vision   | Attending I<br>ir death.<br>octor: After<br>by the funer  | atio           | 1 Natural 5 Pending 2 Accident investigate  | on   | rous, inju  |   | Yes 2 □No   |                                  |                                   |  |  |  |
|          | e Hospital or Attending   24 hours after death. 9 Funeral Director: After etely filled in by the funer  | Certification: | 3 ☐ Suicide 6 ☐ Could not<br>4 ☐ Homicide determined  |  |   |   |   |                                  |                                   |  |  |  |
|          | To the Hospital or Attendii within 24 hours after death. To the Funeral Director: A completely filled in by the fu  | edicai         | 29a. Certifier  (Check only one)  Certifying P  2 Medical Exa   | miner: On the basis of   | To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. In the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) individual manner stated. |   |   |                                  |                                   |  |  |  |
| •        | To the comple   | Σ.             | 29b. Signature and title of certifier   | Tomsko   | Mag, Th   | 29c. License  | 5/9/6   | 2                                | 9d. Date signed (M<br>DeC, J      | 7, 2005  |  |  |
|          | 12  |                | 30 Name and address of person who   | to Nay, 11   | 119 Roc   | pe./Print) //e f  | ike, G-   | 100, Ro                          | ckville,                          | MD 20852   |  |  |
|          | Sta<br>Registr  |                | 31. Date filed (Month, Day, Year) DEC 2 8 2005  | 32/Registra  | r's Signature   | de l  | /   | /                                |                                   |  |  |  |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) Month Y*e*er 7 Au **Physician** 24 2005 90 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Fecility Name (If not institution, give street and number) Examiner Montgomery Burtonsville Holy Cross Rehab Center If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 87 1 ☐ M 2 🖾 F 12-06-1918 Pennsylvania 159-01-4302 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location the Maryland 10b. County 10a, State 28a-f show sthan "natural", or items 23a or 28a-f show the Medical Exaction must be rigilised at 1 XYes 2 No **Funeral Director** New Orleans Orleans 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA. 70125 2820 Burdette St. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 22 No If Yes, Give Year or Dates: 11. Marital Status Black, White, etc Pages 1 and 2 should be filed within 72 hours after Specify: White 1 Never Married 2 Married 1 ☐ Yes 2KNo Baltimore, Maryland 21215-0036 þ 3₺ Widowed 4 Divorced 16b. Kind of Business/Industry Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) item 27 is marked other than item 27 is marked other than other traumatic avent. Le Ma Elementary/Secondary (0-12) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Unknown Jowarski Joseph Bilinski 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1967 Kennedy Dr. McLean VA 22102 Christina E. Hess/daughter permit. Pages 1 and 2. Department of Health a Important: If item 27 is any injury or other trau QDCs. 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Chesapeake Crematory 12-28-2005 Beltsville MD \* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rapp Funeral & Cremation Service 933 Gist Av Silver Spring MD 20910 MO1358 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Idvance of Deerenho Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): by Physician/Medical Examiner use as the burial-transit nding physician and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, 23c. If yes, outcome of pregnancy IF FEMALE 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months?
1 Yes 2 No 5 Other (specify) 4 Pregnant at time of death 9 Unknown 9 Unknown ģ 23e. Did tobacco use contribute to the cause of death? s been signed b should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed?

Be Completed 2 Certification:

To the Hospital or Attending Physician: The law requires that the death certificate be executed After this funeral o

within 24 hours after death. To the Funeral Director: A filled in by

State Registrar

Medical

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Injury at Work? 28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

2 **2**(No

Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Description: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number

00054566

3□ DOA

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

140A Earl ropper Road, Sleich 230 Tocoson, MD21286 Bhogaville,

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient

28a. Date of Injury (Month, Day Year)

8 2005

5 Pending investigation

6 ☐ Could not be

determined

25. Was case referred to medical examiner?

1 ☐ Yes 2 No

27. Manner of Death

1 Natural

2 Accident

3 Suicide

29a. Certifier

4 Homicide

(Check only one)

29b. Signature and title of certifier

egistrar's Signature

28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Injury

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. ent's Name (First, Middle, Last) 2. Date of Death **Physician** tudsor nonas /Medical own, or Location of Death Examiner SHOOKLYN Jark If Under 1 Year | If Under 24 Hrs. **Funeral** 12M 2□F Days Mir Director Usual Residence of Decedent the Maryland County 10d. Inside City Limits 28e-f show Item 27 is marked other than "natural", or liame 23a or 28e-f shov other traumatic event, the Modical Examiner right to notified at 1 Yes 2 THO To Be Completed by Funeral Director 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death a Department of Health and Mehal Hygiene.
Important: If tem 27 is marked other than "ratural", or Itame 23s any injury or other traumatic event, the Modical Examinar mast 14. Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Neyer Married 2 Married ☐Yes 2☐Mo Baltimore, Maryland 21215-0036 Yes, Give 1 Yes 2 No Specify 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working vite, DO NQT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Sero idary (0-12) College (1-4or 5+) 19b. Mailing Address (Street and 620 20b. Place of Disposition Complety, cremator r LIPSurial 2 Cemation
4 Donation 5 20c. 3 Remov 5 Other (Specify) 21. Signatura Funeral Service Licensee s of Facili DOC B. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode shock, or heart failure. List only one cause each line. Approximate Interval Between Ox et and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury sequence of): Examiner The law requires that the death certificate be executed as the burial-transit that initiated events resulting in death) Last and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, has been signed by the attending physician Physician/Medicai IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy certificate 1 ☐ Yes or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 (1) Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 27. Manner 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred within 24 hours after death. To the Funeral Director: After Malural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 \( \text{Homicide} \) To the Hospital 1 Lertifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and the of certifier ( 29c. License number 29d. Date signed (Month, Day, Year) 1200

State Registrar

31. Date filed (Month, Day, Year)

32. Registrar's Signature ORIGINAL

021

|                   |  |  | For State   | State of Ma   |  | artment of Health  |  | 1   | 111113            | 1.1809   |  |
|-------------------|--|--|---|---|--|--|--|---|-------------------|--|--|
|                   |  |  | Registrar  1. Decedent's Name (First, Middle, La  | ast)  | Cei                                    | Tilicate of Deati  |  | Reg. <sup>5</sup> No<br>ate of Death      | 000               | 3. Time of Death                                   |  |
| п                 | Physicia   |  | L'asTi alal   | Aliesa  | HARdy                                  |  | l N  | Month Dar<br>ECEMBER                      |                   | 05 00:38A  |  |
|                   | /Medic<br>Examin   |  | 4a. Facility Name (If not institution, give   | /e street and number)                                 | MANAY                                  | 4b. City, Town, or Location                                |  |   | . County of Dea   |  |  |
|                   | Lxamiii  | Ŭ.   | GREATER BALTIM  | ORE MEDIC   | AL CENTE                               | R TOWSON   |  | В   | ALTIMO            | RE   |  |
|                   | Funeral  |  |   | Sex 7. Age<br>1 □ M 2 1 F                             | (In yrs. last birthday)                | If Under 1 Year If Under 1 Months Days Hours               | er 24 Hrs. 8. D  | ate of Birth<br>Month, Pay, Year)         | 9. Bir            | thplace (State or Foreign                          |  |
|                   | Director   |  | Usual Residence of Decedent   |   | Yrs.                                   |  | 22 1   | 2/21/0                                    | 5 /               | ARYLAND  |  |
|                   | land<br>ow   | -  | 10a. State 10b. County  |   | 10c. City, Town or Lo                  | cation   |  |   |                   | 10d. Inside City Limits                            |  |
|                   | Many<br>Be-f sh  | tor  | Maryland BALTIM   | TORE  | OWING                                  | s Mills  |  |   |                   | 1 ☐ Yes 2 No                                       |  |
|                   | or 28  | Director   | 10e. Street and Number  | 1 -   |  | 10f. Zip Code  |  | 10g. Cit                                  | tizen of What Co  | ountry?  |  |
|                   | ath w  | rall   | 115 Willow B  | end De  | IVE                                    | 21117  | Origin? /Consider  | Van ar Na                                 | 14. Race - Ame    | nican Indian                                       |  |
|                   | ter de<br>Items  | Funeral  | 11. Marital Status  1     Never Married 2     Married   | 12. Was Decedent E<br>Armed Forces?<br>1 □ Yes 2 ☑ No |  | Was Decedent of Hispanic C<br>If Yes, specify Cuban, Mexic | an, Puerto Ricar   | n, etc.)                                  | Black, Whi        |  |  |
| 936               | urs af   | by   | 3 ☐ Widowed 4 ☐ Divorced  | 1 ☐ Yes 2 No<br>If Yes, Give<br>Year or Dates:        |  | 1 ☐ Yes 2 ☑ No Specif                                      | fy:  |   | Specify:          | Black  |  |
| 21215-0036        | I within 72 hours after death with the Maryland<br>liene.<br>Then "neturelt, or Items 23e or 28e-f show<br>the Medical Evant act must be notified at               | Completed  | 15. Decedent's E<br>(Specify only highest gr  |   | (Give                                  | dent's Usual Occupation<br>kind of work done during me     | ost of working   | 16b. K                                    | ind of Business   | /Industry  |  |
| 2                 | within<br>ene.<br>then "   | mpi  | Elementary/Secondary (0-12)   | College (1-4or 5-                                     | life.                                  | DO NOT use retired)  | NE   |   | North             |  |  |
| 2                 | be filed v<br>tal Hygie<br>d other t<br>event, th  |  | 17. Father's Name (First, Middle, Las   | 1)  | 7                                      | ,, -,  |  | st, Middle, Maiden                        | 77 07-0           |  |  |
| /lan              | be od o  | To Be  | WAYNE   |   | HARdy                                  | D  | ANIElle  | V   | Boo               | Ker  |  |
| Maryland          | 12 sho   |  | 19a. Informant's Name/Belationship  | (Type, Print) Pep                                     | 19b. Maili                             | ng Address (Street and Num                                 | ber or Rural Ro  | te Number, City of                        | or Town, State,   | Zip Code)  |  |
|                   | s 1 and<br>f Health<br>item 27<br>other tr   |  | 20a. Method of Disposition  |   | 20b. Place of Dispo                    | psition (Name of matory or other place)                    | Date   | 20c. L                                    | ocation - City or | Town, State  |  |
| e E               | 0 = =  |  | 1 Burial 2 Cremation 3 ( 4 Donation 5 Other (Spec   | □Removal from State ify)                              | (PREEN)                                | MaINT  | 12/2/2   | 775 BA                                    | I Mon             | 2.MI   |  |
| Baltimore,        | permit. Pag<br>Department<br>Important: I<br>eny injury c  |  | 21. Signature of Funeral Service Lice   | ensee   | 22                                     | Name and Address of Fac                                    | THE PARTY OF THE P | ever w. :                                 | SENRINS           | AND SONS CO.                                       |  |
| 8                 | 8255   |  | Kathlan   | HZO   |  | 16924807   | S, MON   | IKTON                                     | MD                | 21111  |  |
|                   |  |  | 23a. Part1. Enter the disease, or cor<br>shock, or heart failure. List only                                 | nplications that caused yone cause on each lin        | the death. Do not ent<br>e.            | er the mode of dying, such a                               | as cardiac or res  | piratory arrest,                          |                   | Approximate<br>Interval Between<br>Onset and Death |  |
|                   | Physician  |  | Immediate Cause (Final disease or condition resulting in death)   | a. Cord   | prolap                                 | se   |  |   |                   | The 32 min   |  |
|                   | /Medical<br>Examiner   |  |   |   | consequence of):                       | ire of membro  | W10.00   |   |                   | 2 days   |  |
|                   | 4.   | er   | Sequentially list conditions, if any, leading to immediate  | U   | consequence of):                       | ic of memore   | ),,,,,,  |   |                   |  |  |
|                   | cuted  | Examiner   | cause. Enter Underlying Cause (Disease or injury that initiated events                                      | C   |  |  |  |   |                   |  |  |
| 0,                | The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit |  | resulting in death) Last  | Due to (or as a                                       | consequence of):                       |  |  |   |                   |  |  |
| 8760,             | cate by  | dical  | •   | d   |  |  |  |   |                   |  |  |
| 9                 | leath certifica<br>attending ph  |  | IF FEMALE:  | 23c. If yes, outcome of                               | of pregnancy                           |  |  |   | 23d. Date of de   | livery   |  |
| Вох               | atten<br>atten   | Physician/Me   | 23b. Was decedent pregnant in the past 12 months?  1 \( \subseteq \text{Yes} \) 2 \( \subseteq \text{No} \) | 1 ☐ Live birth 2<br>4 ☐ Pregnant at 1                 | 2 ☐ Fetal death 3 ☐                    | Ectopic pregnancy Other (specify)                          |  |   | Month             | Day Year   |  |
| O.                | that the de<br>led by the a<br>detached  | hysi   | 9 Unknown   | 9□ Unknown  |  |  |  |   |                   |  |  |
| s, Р              | ss that<br>gned I  |  | Part II. Other significant conditions   | _   | t not resulting in the u               | nderlying cause given in Pai                               | rt I.  |   |                   | o the cause of death?                              |  |
| ord               | w requires<br>been signe<br>should be  | ted  | Extreme prematur  |   |  |  |  | 1 Yes 2                                   | Mo 3□P            | robably 4 Unknown                                  |  |
| of Vital Records, | e law r<br>has be<br>je 2 sh   | Completed by   | Bleeding from   | loceration  | chest and                              | abdomen.   |  | 24a. Was an autopsy                       | prior to          | utopsy findings available completion of cause of   |  |
| <u>=</u>          |  | Con  |   |   |  | <u>-</u>   |  | performed?<br>1 ☐ Yes 2 🗷 No              | death?            | s 2□ No  |  |
| Vita              | Physicien: The this certificate ral director, pag  | Be   | 25. Was case referred to medical examiner?  | Hospital:   |  |  | ice of Death (Ch   |   |                   | -  |  |
| of                | Phys<br>r this<br>rral di  | Other: 4 Nursing Home 5 Residence 6 Other (Specify)  27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide  1 Nursing Home 5 Residence 6 Other (Specify)  28a. Date of Injury (Month, Day Year)  28b. Time of Injury Mn 1 Yes 2 No  28c. Injury at Work? M 1 Yes 2 No  28d. Describe how injury occurred   |   |  |  |  |   |                   |  |  |
| lon               | nding<br>tth.<br>:: Afte<br>e fune   |  |   |   |  |  |  |   |                   |  |  |
| Division          | To the Hospitel or Attending Phwithin 24 hours after death. To the Funerel Director: After th completely filled in by the funeral                                  | rtifica  | 3 Suicide 6 Could not determine   |   | ry - At home, farm, st.<br>. (Specify) | reet, factory, office                                      |  | ocation (Street ar<br>City or Town, State |                   | ural Route Number,                                 |  |
|                   | pitel o  |  | 29a. Certifier 17 Certifying F  | hyeician: To the best o                               | f my knowledge, deat                   | h occurred at the time, date                               | and place, and o   | tue to the cause/s                        | and manner a      | e stated   |  |
|                   | To the Hospite within 24 hours To the Funerel completely filled  | Medical  |   |   | examination and/or in                  | vestigation, in my opinion, d                              |  |   |                   |  |  |
|                   | To the within To the Comp  | ž  | 29b. Signature and title of certifier   |   |  | 29c. License numbe   |  |   | ite signed (Mon   |  |  |
|                   |  |  | Augela H.   |   |  | D522   |  | /2  | -22-0             | 5  |  |
| 1                 |  |  | 30. Name and address of person who  | completed cause of de                                 | eath (Item 23a) (Type,                 | Print) ANGELA TI   | OMAMA  |   | 201               |  |  |
|                   | C+   | ate.   | 31. Date filed (Month, Day, Year)   | 32. Poistra   | r's Signature                          | L  | ,179771  | und 214                                   | 204.              |  |  |
|                   |  | State Registrar DEC 2 8 2005  Store DEC 2 8 2005  Store DEC 2 8 2005  Store DEC 2 8 2005  Store DEC 2 8 2005   |   |   |  |  |  |   |                   |  |  |

|             |   |  | For<br>State<br>Registrar  | State of M   | larylan                 |   | artmen<br>rtificate                             |                         |                                    |                                 | F   | leg. No.                       | 5 !                        | +1810  |
|-------------|---|--|--|--|-------------------------|---|---|-------------------------|------------------------------------|---------------------------------|---|--------------------------------|----------------------------|--|
|             | Physici   |  | Decedent's Name (First, Middle, L.   | ast)<br>MARK   | C.                      | HUSS                                      | S   |                         |                                    |                                 | 2. Date of Dea<br>Month<br>EMBER                  | Day<br>25, 20                  | Year<br>1015               | 3. Time of Death                                   |
|             | /Medio<br>Examin  |  | 4a. Facility Name (If not institution, go<br>Saint Joseph  | ve street and number,<br>Medical                                       | Cent                    | er  | 4b. City,                                       | Town, or                |                                    | of Death                        |   | 4c. County                     | y of Death                 |  |
|             | Funeral<br>Director   |  | 320 10 1303  | Sex<br>XXM 2□F   | ge (In yrs. 1<br>88     | last birthday)<br>Yrs.                    | If Under<br>Months                              | 1 Year<br>Days          | If Under<br>Hours                  | 24 Hrs.<br>Min.                 | 8. Date of Birth<br>Month Day<br>09-13-           | 1917                           | 9. Birthr<br>Cour<br>IL    | place (State or Foreign<br>ntry)<br>LNOIS          |
|             | Maryland  | tor  | Usual Residence of Decedent  10a. State 10b. County  MD. BALTI   | MORE   | 10c. City               | y, Town or Lo                             |   | BALDW                   | VIN                                |                                 |   |                                | 1                          | 10d. Inside City Limits 1 ☐ Yes 2 XXVo             |
|             | with the<br>a or 28s  | Direc  | 10e. Street and Number 4100 KINCAID  | ROAD   |                         |   | 10f. Zip  | Code<br>210             | 113                                |                                 |   | 10g. Citizen of                | What Coul                  | •  |
| 980         | permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene important: If item 27 is marked other then "natural", or items 23a or 28a-f ehow important: If item 27 is marked other then "natural", or items 23a or 28a-f ehow appropriately from the Maryland of Exercitive cuts. Item in confidence and once. | by Funeral Director                                  | 11. Marital Status  1 Never Married XX Married 3 Widowed 4 Divorced  | 12. Was Decedent   | ?<br> No<br>  1.1   1.1 |   | Was Deced<br>If Yes, spec                       | ent of Hi               |                                    | gin? (Spe<br>i, Puerto F        | cify Yes or No-<br>Rican, etc.)                   |                                | ce - Americ<br>ck, White,  | can Indian,  |
| 21215-0036  | within 72 ho<br>iene.<br>• then "natur<br>the Madical   | Completed  | 15. Decedent's (Specify only highest g   | Education<br>rade completed)  College (1-4or<br>4 YEARS                | 5+)                     | (Give                                     | dent's Usua<br>kind of wo<br>DO NOT us<br>IASON | rk done d<br>se retired | ation<br>during mos<br>)<br>)FFICE |                                 | g   | 16b. Kind of B                 |                            |  |
| Maryland 2  | 12 should be filed within h and Mental Hygiene. 7 is marked other then "traumatic event, the Mas  | To Be C  | 17. Father's Name (First, Middle, Las<br>JA  | st)  |                         |   |   |                         | 18. Mothe                          |                                 |   | Maiden Sumai<br>CRANDAI        |                            |  |
| Mary        | od 2 sho Ith and Ith  |  | 19a. Informant's Name/Relationship (Type, Print)  BARBARA J. DREYER (DAUGHTER)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town 2600 GARRETT ROAD, WHITE HALL, MARYL   |  |                         |   |   |                         |                                    |                                 |   |                                |                            |  |
| Baltimore,  | Pages 1 annent of Heal  |  | 20a. Method of Disposition  1 Burial XX Cremation 3 4 Donation 5 Other (Spec   | □Removal from State  |                         | Place of Dispo<br>emetery, crea<br>LTOP S | matory or o                                     | ther plac               | )RP. 1                             |                                 | -2005   | 20c. Location                  |                            | own, State<br>LAND, 21204                          |
| Balti       | permit. Departrimporta any inju   |  | 21. Signature of Funeral Service Lic   | ensee (  | R.G.R                   |   | 2. Name an                                      |                         |                                    |                                 | HOME, I   | NC. TO                         | 50 YO<br>WSON,             | RK ROAD<br>MD.21204                                |
|             | Physician<br>/Medical   |  | 23a. Part1. Enter the disease, or co<br>shock, or heart failure. List on<br>Immediate Cause (Final<br>disease or condition<br>resulting in death)  | mplications that cause by one cause on each a. CHRONI  Due to (or a    | line.<br>C OB           | STRUC                                     |   |                         |                                    |                                 |   |                                |                            | Approximate<br>Interval Between<br>Onset and Death |
| Ù,          | rate be executed by sician and the burial-transit   | Ical Examiner  | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last   | b. — Due to (or a:  C Due to (or a:  d                                 |                         |   |   |                         |                                    |                                 |   |                                |                            |  |
| P.O. Box 68 | law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit  | Physician/Med  | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  | 23c. If yes, outcom<br>1 ☐ Live birth<br>4 ☐ Pregnant a<br>9 ☐ Unknown | 2 Feta                  | Ideath 3[                                 | ⊒Ectopic pr<br>⊒ Other (sp                      |                         |                                    |                                 |   |                                | ate of deliv               | ery<br>Day Year                                    |
| rds, P.     | quires that I<br>n signed by<br>uld be deta   | by   | Part II. Other significant conditions  | contributing to death  | but not res             | ulting in the u                           | inderlying c                                    | ause give               | en in Part I                       |                                 | 23e. Did to                                       | A.                             |                            | the cause of death? bably 4 Unknown                |
| ď           | The law requir<br>ete has been si<br>pege 2 should I  | Completed  |  |  |                         |   |   |                         |                                    |                                 | 24a. Was<br>autop<br>perfor<br>1 \( \text{Yes} \) | an 24b.<br>sy<br>rmed?<br>2 No | Were autoprior to codeath? | opsy findings available ompletion of cause of      |
| Vital       | Physician:<br>this certifice<br>al director, j  | Be   | 25. Was case referred to medical examiner?   | Hospital:  |                         |   |   | Oth                     | or                                 |                                 | (Check only o                                     |                                |                            |  |
| of          | fe je   | 1 Mainpatient 2 EH/Outpatient 3 DOA 4 Nursing Home 5 |  |  |                         |   |   |                         |                                    | lence 6 ∐Oti<br>now injury occu |   | fy)                            |                            |  |
| Division    | ≥ ਜੂੰ ਜੂਂ ∈   | Certifica  | 27. Manner of Death  1 Natural  2   Accident  3   Suicide  4   Homicide  28a. Date of Injury (Month, Day Year)  28b. Time of Injury M  28c. Injury at Work?  1   Yes 2   No  28d. Describe how in Injury M  28d. Describe |  |                         |   |   |                         |                                    |                                 | ber or Aur  | al Route Number.               |                            |  |
|             | Hospital     24 hours     Funeral     letely filled   | dical  | 29a. Certifier 1 Certifying (Check only one)   | Physician: To the bes<br>aminer: On the basis<br>and manner s          | of examina              | owledge, deal<br>ition and/or in          | th occurred<br>ivestigation                     | at the tin              | ne, date an<br>pinion, dea         | id place, a<br>ith occurre      | and due to the ded at the time,                   | cause(s) and m                 | anner as s<br>, and due t  | stated.<br>to the cause(s)                         |
|             | To the within 2 To the complet  | Me   | 29b. Signature and title of certifier  |  |                         |   | 290   | c. Licens               | e number                           |                                 |   | 29d. Date signe                |                            | **   |
|             |   |  | 20 Name and address  | o complaint course of  | doath /hr               | n 23a\ /T                                 |   | 3725                    | 54                                 |                                 |   | 12/2                           | 275                        | 7  |
|             | 5+1   |  | 30. Name and address of person wh  | 7601   | OSLE                    | R DRI                                     | VE.   | TOWS                    | 30N.                               | MAR                             | YLAND   | 21204                          |                            |  |
| 16.         | Sta<br>Regist   | ate<br>rar   | 31. Date filed (Month, Day, Year)  DEC 2 8 2005  | 32. Regis  | trar's Signa            | ature                                     |   |                         |                                    |                                 |   |                                |                            |  |

|  |   |   | 1 - For<br>State<br>Registrar   | State of M                        | faryland i                     |                | artment  |                    |              | and Mei        |   | iene                   | ; 4                         | 1811   |
|--|---|---|---|-----------------------------------|--------------------------------|----------------|--|--------------------|--------------|----------------|---|------------------------|-----------------------------|--|
|  | Physicia<br>/Medic  |   | 1. Decedent's Name (First, Middle, Last)  Mary B.   | Idzik                             |                                |                |  |                    |              | 2.<br>I        | Date of Deat<br>Month<br>Decembe        | er 26, 2               | 2005                        | 3. Time of Death 3:00 pm M                       |
|  | Examin  |   | 4a. Facility Name (If not institution, give str   |                                   | r)                             |                | 4b. City,                                      | Town, or           | Location o   | Death          |   | 4c. County             |                             |  |
|  |   |   | 4015 Buckingham Roa   |                                   | // /A                          | to beat of a 1 | Ba<br>If Under                                 | 1tin               | nore         | 24 Hre o       | Data d Blat                             |                        |                             | County   |
|  | Funeral<br>Director   |   | 5. Social Security Number 6. Sex 1 □ N  | 2/TyF /                           | ige (In yrs. last<br>88        | Yrs.           | Months   | Days               | Hours        | Min. At        | Date of Birth<br>(Month, Day,<br>18 20, | Year)                  | 9. Birth                    | place (State or Foreign<br>ptry)                 |
|  | σ   |   | Usual Residence of Decedent   | /1                                |                                |                |  |                    |              |                |   |                        |                             |  |
|  | show  | _   | 10a. State 10b. County  |                                   | 10c. City, T                   |                |  |                    |              |                |   |                        | 1                           | 10d. Inside City Limits                          |
|  | 8e-f  | ecto  | MD Baltimor   | e                                 | В.                             | altin          |  | 0.1:               |              |                |   | 0                      |                             | 1 ☐ Yes 2 ☐ No                                   |
|  | with t  | Funeral Director  | 10e. Street and Number 4015 Buckingham Roa  | ıd                                |                                |                | 10f. Zip                                       |                    | 21207        |                | "                                       | 0g. Citizen of V<br>US |                             | ntry r   |
|  | death<br>ms 23  | nera  |   | Was Deceden                       | t Ever in U.S.                 | 13.            | Was Deced                                      | ent of Hi          | spanic Orig  | gin? (Specif   | y Yes or No-<br>can, etc.)              |                        |                             | can Indian,                                      |
| 9  | within 72 hours after death with the Maryland ene. than "natural", or Itams 23e or 28e-f show then "natural Exercites must be notified at |   | 1 Never Married 2 Married   | 1 Yes 2 If Yes, Give              |                                |                | 1 ⊡ Yes 2                                      |                    | Specify:     | , Pueno nio    | an, etc.)                               | Specify                | k, White,                   | nite   |
| 8  | hours<br>ural',   | Completed by  | 3 XWidowed 4 □ Divorced   | Year or Dates                     |                                |                |  |                    |              |                |   |                        |                             |  |
| 21215-0036   | in 72<br>"nat   | olete   | 15. Decedent's Educa<br>(Specify only highest grade of  | ompleted)                         |                                | (Give          | dent's Usua<br><i>kind of wor</i><br>DO NOT us | k done d           | lurina most  | of working     |   | 16b. Kind of Bu        | .siness/in                  | idustry  |
| 212  | d with<br>giene.  | mo  | Elementary/Secondary (0-12)   | College (1-4o                     | r 5+)                          | Hor            | nemake   | er                 |              |                |   | Domes                  | tic                         |  |
| pu   | al Hygant,  | Bec   | 17. Father's Name (First, Middle, Last)   |                                   |                                |                |  |                    |              |                |   | Maiden Sumam           | ө)                          |  |
| yla  | ould b  | Vincent Dadurka    Mary Dargavi   19a. Informant's Name/Relationship (Type, Print)   Mrs. Theresa Seeley (Daughter)   4015 Buckingham Road Baltimor |   |                                   |                                |                |  |                    |              |                |   |                        | -100 -                      |  |
| altimore, Maryland   | d 2 sh<br>th and<br>th sn<br>traun  |   |   |                                   |                                |                |  |                    |              |                |   | -                      |                             | Code)  |
| ē,   | s 1 and 2<br>of Health a<br>item 27 Is  |   |   |                                   |                                |                |  |                    |              |                |   | 20c. Location -        |                             | own, State                                       |
| E  | Pages<br>nent of<br>nt: If i  |   | 1 ☑ Burial 2 ☐ Cremation 3 ☐ Rer<br>1 ☑ Donation 5 ☐ Other (Specify)  | noval from Stat                   | θ                              | •              | /alley   |                    | n. Gai       | 12/30/<br>rd.  | /05 <sub>]</sub>                        | fimoniu                | n, MJ                       | D  |
| Balti  | permit. Departm Imports any Inju  |   | 21. Signature of Funeral Service Licensee   | right                             | 4                              |                | · · · · · · · · · · · · · · · · · · ·          |                    |              |                |   | PEL PA<br>0-795-14     | L. PA (Box 195)<br>795-1400 |  |
|  |   | v   | 23a. Part1. Enter the disease, or complica shock, or heart failure. List only one   | tions that cause<br>cause on each | ed the death. [                |                |  |                    |              |                |   |                        |                             | Approximate<br>Interval Between                  |
|  | Pnysician   | 8 1   | Immediate Cause (Final disease or condition   |                                   | 1.VI                           | MAN            | ion  | A                  |              |                |   |                        | 1                           | Onset and Death                                  |
|  | /Medical<br>Examiner  |   | resulting in death)   | Due to (or a                      |                                | ce f):         |  |                    |              |                |   |                        |                             |  |
|  |   | er  | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Causs (Uisease or injury                     | Due to (or a                      | ıs a consequen                 | ce of):        |  |                    |              |                |   |                        | -                           |  |
| 6  | outed<br>id<br>ansit  | Examine   | cause. Enter Underlying Cause (Uisease or injury that initiated events  |                                   |                                |                |  |                    |              |                |   |                        | -                           |  |
| 00   | e exec  |   | resulting in death) Last  | Due to (or a                      | is a consequen                 | ce of):        |  |                    |              |                |   |                        |                             |  |
| 8760,  | icate be executed<br>physician and<br>s the burial-transit  | dlca  | d   |                                   |                                |                |  |                    |              |                |   |                        |                             |  |
| Box 6  | death certificate be executed<br>e attending physician and<br>of for use as the burial-transi   | Physician/Medical   | IF FEMALE: 23b. Was decedent pregnant 23c   |                                   | e of pregnancy                 |                |  |                    |              |                |   | 23d. Dat               | e of delive                 | ery  |
|  | death<br>e atte   | lcia  | in the past 12 months?  | 4□Pregnant                        | 2 Fetal de<br>at time of death |                | Ectopic pre<br>Other (spe                      |                    |              |                |   | Mor                    | nth                         | Day Year   |
| P.O.   | that the digital the post of the detached   | hys   | 9 🗆 Unknown   | 9☐ Unknown                        |                                | _              |  |                    |              | 1              |   |                        | 1 7 7 7                     |  |
|  | 8 6 9   | by  | Part II. Other significant conditions contri  | buting to death                   | but not resultin               | ig in the u    | nderlying ca                                   | ause give          | n in Part I. |                | 23e. Did tob                            |                        |                             | he cause of death?                               |
| orc  | ned   | Completed   |   |                                   |                                |                |  |                    |              |                |   |                        |                             |  |
| Rec  | e la<br>has<br>je 2   | ldm   |   |                                   |                                |                |  |                    | -            |                | 24a. Was au<br>autops<br>perform        | ned?                   | rior to co<br>leath?        | ppsy findings available<br>impletion of cause of |
| Vital Records,   |   | e Co  | 25. Was case referred to medical  |                                   |                                |                |  |                    | 26 Place     | of Death //    | 1 ☐ Yes 2<br>Check only on              |                        | ☐ Yes                       | 2 No   |
| Ž  | lis dir   | To B  | examiner?   | pital:<br>1□Inpa                  | tient 2 ER                     | Outpatier      | nt 3 DO  | A Othe             |              |                | -                                       | nce 6 Othe             | er (Specil                  | (y)  |
| n of   |   |   | 27. Manner of Death 1 □ Natural 5 □ Pending   | 28a. Date of In<br>(Month, D      | jury 28<br>Day Year)           | b. Time of     | 21   | 8c. Injury<br>Work | at<br>?      | 280            | I. Describe ho                          | w injury occurr        | be                          |  |
| Sio  | en<br>eatl<br>or:<br>he   | catl  | 2 Accident investigation 3 Suicide 6 Could not be   | 00. 81                            |                                |                | М  | -                  | /es 2□N      |                | Lanting (Ct                             | and and Alexandr       |                             | 10-11  |
| Division   | or Attendater deat<br>Diractor:   | ertification;   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  28f. Location (Street City or Town, St. |                                   |                                |                |  |                    |              |                |   |                        | ar or Hura                  | al Houle Number,                                 |
| _  | a Hospital or Att<br>124 hours after de<br>6 Funaral Diract<br>letely filled in by t  | O   | 29a. Certifier 1 Certifying Physic  | ien: To the bes                   | st of my knowle                | dge, deat      | h occurred a                                   | at the tim         | e, date and  | d place, and   | I due to the ca                         | ause(s) and ma         | nner as s                   | tated.   |
| 29a. Certifier (Check only one)  29a. Certifier (Check only one)  29b. Signature and the time, date and place, and due to the cause(s) and manner as stated.  29c. License number  29d. Date signed (Month, Day, Year) |   |   |   |                                   |                                |                |  |                    |              | o the cause(s) |   |                        |                             |  |
|  | To the within 2.  | Σ   | 29b. Signature and the second signature   | <b>\$</b>                         | Mb. d                          | ina            |  | License            | number       | C              |   | 9d. Date signed        |                             |  |
| ,  | - 6   |   |   |                                   | 1 101-10-                      |                |  | DI                 | 111.         | 8              |   | Jec 2                  | 1, 2                        | 005  |
|  | 10  |   | 30. Name and address of person who com  | Rtz 1                             | death (Item 23                 | a) (Type,      | 2 Ne   | wla                | nd ,         | Rd             | 2121                                    | 8                      |                             |  |
|  | Sta   |   | 31. Date filed (Month, Day, Year)   |                                   | strar's Signature              |                |  |                    |              |                |   |                        |                             |  |
|  | Registr   | ar  |   |                                   |                                |                |  |                    |              |                |   |                        |                             |  |

|          |  |                |  | State of Maryland / Dep   |  | Mental Hygier                                   | Chi alle arts come E a se as as  |
|----------|--|----------------|--|---|--|---|--|
|          | Physici  | an             | 1. Decedent's Name (First, Middle, Last)   |   |  | 2. Date of Death<br>Month                       | Day Year 3. Time of Death  |
| V        | /Medic   | al             | 4a. Facility Name (If not institution, give si   |   | 4b. City, Town, or Location of Death   | DECEMBL   | E/2 Z / 205 3 365 M  4c. County of Death                                 |
|          | Examin   | er             |  | IRS HOSPITAL  | BALTIMOR   |   | NA   |
|          | Funeral<br>Director  |                | 5. Social Security Number 6. Sex 1□  | M 2 7. Age (In yrs. last birthday                                   | y) If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.                      | 8. Date of Birth<br>(Month, Day, Yea<br>03 14 1 | ar) 9. Birthplace (State or Foreign Country) (9/5                        |
|          | yland<br>yland   |                | Usual Residence of Decedent  10a. State 10b. County  | 10c. City, Town or L  | ocation  |   | 10d. Inside City Limits  |
|          | 72 hours after death with the Maryland<br>naturel', or Herne 23e or 28e-f ehow<br>disel Examinat Leundflied at             | Director       | Md. NA   | Balti   |  |   | 1 Yes 2 □ No   |
|          | with the   | Dire           | 10e. Street and Number   | 1-11- 1-10  | 10f. Zip Code  | 10g.  | Citizen of What Country?   |
|          | death  | Funeral        | 11. Marital Status   | 2. Was Decedent Ever in U.S. 13. Armed Forces?                      | . Was Decedent of Hispanic Origin? (SI<br>If Yes, specify Cuban, Mexican, Puerto | pecify Yes or No-                               | 14. Race - American Indian,  |
| 36       | s after<br>, or Ita  | by Fu          | 1 ☐ Never Married 2 ☐ Marned 3 🛣 Widowed 4 ☐ Divorced  | 1 ☐ Yes 2 X No<br>If Yes, Give                                      | 1 ☐ Yes 2 No Specify:  | nican, etc.)                                    | Black, White, etc.   |
| 5-0036   | 72 hours<br>"natural"  |                | 15. Decedent's Educ  |   | edent's Usual Occupation   | 16b.  | B/GCK Kind of Business/Industry  |
| 21       | be filed within 72 houseld Hygiene. Ind other then "nature event, Ine Modical  | Completed      | (Specify only highest grade Elementary/Secondary (0-12)  | College (1-4gr 5+)  | re kind of work done during most of work  DO NOT use retired)  -                 | king  | ) +  |
| 121      | filed w<br>Hygier<br>Ither th  |                | 17. Father's Name (First, Middle, Last)  | O B   | Beautician 18 Mother's Nam   | ne (First, Middle, Maid                         | MIVALE ULUWED  |
| lan      | 2 should be filed<br>and Mental Hygi<br>is marked other<br>aumatic event, II   | To Be          | William Sm   | vith.   | 001  | 10 Regist                                       | L - 11   |
| Aary     | d 2 should<br>th and Mer<br>7 is marke<br>traumatic  |                | 19a. Informant's Name/Relationship (Typ  | e, Print) (daughter) 19b. Mai                                       | ling Address (Street and Number or Ru  | ral Route Number, Cit                           | y or Town, State, Zip Code)  |
| e, P     | s 1 and<br>if Health<br>Itam 27<br>othar ti  |                | Jean Carwile  20a. Method of Disposition   | 20b. Place of Disp  | position (Name of  | Aue Bal<br>Date 200.                            | Location - City or Town, State   |
| altimor  | 0 = 5<br>0 = 5   |                | 1 Burial 2 Cremation 3 □Re<br>4 □Donation 5 □ Other (Specify)  | emoval from State   | ematory or other place)  | 29-7000 A                                       | altimore my  |
| alti     | pernit. Pa<br>Departmen<br>Important:<br>Iny injury  |                | 21. Si mature of Funeral Service License   | • )   | 22. Name and Address of Facility OSEPH L. RUSS FO                                | ineral Hol                                      | ne P.A   |
| m<br>m   | 40 E = 8   |                | 23a. Part1. Enter the disease, or complic  | uss o   | 2222 W. North AUG  | Baltimo   | Approximate  |
|          | Physician<br>/Medical  |                | shock, or heart failure. List only on<br>Immediate Cause (Final<br>disease or condition<br>resulting in death) | Acute   | Pulmon ARy   |   | Interval Between   |
|          | Examiner   |                |  | Due to (or as a consequence of):                                    | ic Cardiony  | orathe  | Veger  |
|          | p #  | Iner           | Sequentially list conditions, if any, leading to immediate cause. Enter Undertying                             | Due to (or as a consequence of):                                    | y control y  | 1   |  |
| ۲        | xecute<br>and  | Examin         | Cause (Disease or injury that initiated events resulting in death) Last  | Due to (or as a consequence of):                                    |  |   |  |
| 8760     | cate be executed obly sicien and the burial-transit  | dicai E        | <b>€</b> d.  |   |  |   |  |
| 9        | artifica<br>ing phy<br>e as th   | Medi           | IF FEMALE:   |   |  |   |  |
| Вох      | eath certific<br>attending p   | cian/          | in the past 12 months?   |   | ☐Ectopic pregnancy ☐ Other (specify)   |   | 23d. Date of delivery  Month Day Year                                    |
| P.O.     | t the de<br>by the<br>tached   | Physician/Me   | 1 ☐ Yes 2 StNo<br>9 ☐ Unknown  | 9☐ Unknown  |  |   |  |
|          | The taw requires that the death certific to has been signed by the attending p tage 2 should be detached for use as        | þ              | Part II. Other significant conditions conf   |   | underlying cause given in Part L<br>VAJ culcul wea                               |   | o use contribute to the cause of death?  2 ☑ No 3 ☐ Probably 4 ☐ Unknown |
| Records, | w requir<br>been si<br>should  | leted          | 2 110 66   | ) Felippenac  | VIII COOLOCO ME  | 24a. Was an                                     | 24b. Were autopsy findings available                                     |
| Re       | The tav  | Completed      |  | ,   |  | autopsy<br>performent                           | prior to completion of cause of death?                                   |
| of Vital |  | Be C           | 25. Was case referred to medical examiner?   |   | 26. Place of Dea   | th Check only one                               | 10 703 20 110  |
| of \     | Phys<br>rthis<br>raldi   | . To           | 1 Yes 2 No   | 28a. Date of Injury 28b. Time                                       |  | ome 5 Residence                                 | 6 □Other (Specify)   |
| ion      | Attending Ph<br>death.<br>ctor: After th<br>y the funeral  | atlon          | 1 Natural 5 Pending 2 Accident investigation   | (Month, Day Year) Injury  |  | 250. 50501100 11011 11                          | july boouned   |
| Division | l or Attendater death<br>after death<br>Director:  | Certification: | 3 ☐ Suicide 6 ☐ Could not be determined  | 28e. Place of Injury - At home, farm, s<br>building, etc. (Specify) | street, factory, office  | 28f Location (Street<br>City or Town, Sta       | and Number or Rural Route Number,<br>ate)                                |
|          | To the Hospital or Attending within 24 hours after death.  To the Funaral Director: After completely filled in by the fune |                | 29a. Certifier 1 Certifying Phys   | icien: To the best of my knowledge, dea                             | ath occurred at the time, date and place   | and due to the cause                            | e(s) and manner as stated  |
|          | To the Hospital within 24 hours To the Funaral completely filled   | Medical        | (Check only 2 Medical Examin   | er: On the basis of examination and/or i and manner stated.         | investigation, in my opinion, death occu   | rred at the time, date a                        | and place, and due to the cause(s)                                       |
|          | To t<br>To t   | Σ              | 29b. Signature and title of eartifier  | 3 AMENDING  | 29c. License number  | 29d. [  | Date signed (Month, Day, Year)   |
|          | h  |                | 30. Name and address of person who cor   | noleted cause of death (Item 23a) /Tuno                             | D ( / tto  | ye  | CZZ (2001  |
|          | <b>'</b> D   |                | Paul Sch   | WARTMI- 2   | D 17 (18  D, Print)  B, Print)  B 572 Newland                                    | Rd 28   | 2(8  |
|          | Sta<br>Registr   |                | 31. Date filed (Month, Day, Year) DEC 2 8 200  | 32 Registrar's Signature  | Care   |   |  |

|                            |   | •                             | For<br>State<br>Registrar   | State of Maryland   | Department of Health and Certificate of Death  | Mental Hygiene  | 11115 6 18 18   |
|----------------------------|---|-------------------------------|---|---|--|---|---|
| ı                          | Physici   | an                            | 1. Decedent's Name (First, Middle, Last)  | SON   |  | 2. Date of Death Month DECEMBER                         | 3. Time of Death  |
| سهرزا                      | /Medic<br>Examin  |                               | 4a. Facility Name (If not institution, give s.  | Treet and number)   | TER 4b. City, Town, or Location of Death   | 100 N   | County of Death BALTIMORE   |
|                            | Funeral<br>Director   |                               | 5. Social Security Number 6. Sex 2/4-68-/538  | M $2\Box$ F $\frac{7. \text{ Age (In yrs. last}}{39}$   | birthday) If Under 1 Year II Under 24 Hrs Months Days Hours Min.                                 |   | 9. Birthplace (State or Foreign Country)                                    |
|                            | arytand<br>ehow   | J.                            | Usual Residence of Decedent  10a. State 10b. County   | 10c. City, To   | own or Location  |   | 10d. Inside City Limits  ↑₩₩ es 2 □ No                                      |
|                            | with the M<br>s or 28a-1<br>be notified   | Directo                       | 10e. Street and Number  | OH,   | 11/MOre<br>101. Zip Code<br>2-12/5   | 10g. Ci   | tizen of What Country?  |
| 40                         | s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "natural", or iteme 23s or 28s-f show other traumatic event, the Medical Example number notified a | Completed by Funeral Director | 11. Marital Status 1  To Rever Married 2 Married  | 2. Was Decedent Ever in U.S.<br>Armed Forces?<br>1 ☐ Yes 2 ☐ No   | 13. Was Decedent of Hispanic Origin? (S<br>If Yes, specify Cuban, Mexican, Puer                  | pecify Yes or No-<br>o Rican, etc.)                     | 14. Race - American Indian,<br>Black, White, etc.                           |
| -0036                      | 2 hours at<br>aturai', or   | ted by I                      | 3 Widowed 4 Divorced  | If Yes, Give(<br>Year or Dates:   | 1 ☐ Yes 2 ☐ No Specify:  6a. Decedent's Usual Occupation   |   | Specify: Black Gind of Business/Industry                                    |
| 21215                      | d within 7<br>giene.<br>er than "n<br>, the Medi  | Comple                        | (Specify only highest grade   | College (1-4or 5+)  | (Give kind of work done during most of wo life. DO NOT use retired)                              | Res   | Tourant   |
| Maryland 21215-0036        | 2 should be filed<br>and Mental Hygi<br>is marked other<br>aumatic event, i   | To Be (                       | 17. Father's Name (First, Middle, Last)   | KSON  | Carl   | me (First, Middle, Maider                               | erbey   |
|                            | and 2 sho<br>ealth and<br>m 27 is mu  |                               | 19a. Informant's Name/Relationship (Type Carlin Dverbey   | / mother  | 9b. Mailing Address (Street and Number or Ri   | ve bottimo  | we, Wel. 21215  |
|                            | 2 2 2   |                               | 20a. Method of Disposition 1 ☐ Burial 2 Depending 3 ☐ Ro 4 ☐ Donation 5 ☐ Other (Specify)                                     | emoval from State   | e of Disposition (Name of stery, crematory or other place)                                       | u 23, 7005 BA   | ocation - City or Town, State   |
| Balt                       | permit. Peg<br>Department<br>Important:<br>any injury o   |                               | 21. Signature of Funeral Service License  |   | 22. Name and Address & Fability 42<br>NYLie Funeral Home   | CO Liberty Rosa<br>PA & BATTILLIANS                     | d Radiotain, Ma 21133   |
|                            | Physician   |                               | shock, or heaft failure. List only on<br>Immediate Cause (Final<br>disease or condition                                       | e cause on each line.   | On not enter the mode of dying, such as cardia  I MMUNE DEFECTEA                                 |   | Approximate Interval Between Onset and Death                                |
|                            | /Medical<br>Examiner  |                               | resulting in death)  Sequentially list conditions,  | Due to (or as a consequen   |  |   |   |
|                            | and<br>erransit   | Examiner                      | if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events cresulting in death) Last | Due to (or as a consequen   |  |   |   |
| 8760,                      | cate be executed<br>physicien and<br>the burial-transit   | dical                         | La  |   |  |   |   |
| .O. Box 6                  | The law requires that the death certific<br>sie has been signed by the attending p<br>page 2 should be detached for use as:   | Physician/Med                 | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown                                       | 3c. If yes, outcome of pregnancy<br>1 Live birth 2 Fetal de<br>4 Pregnant at time of death<br>9 Unknown | ath 3 ☐Ectopic pregnancy   |   | 23d. Date of delivery<br>Month Day Year                                     |
| ds, P.                     | uires that<br>signed b<br>Id be deta  | þ                             | Part II. Other significant conditions con [1287 ATITIS]   | tributing to death but not resulting  | g in the underlying cause given in Part I.   | 23e. Did tobacco<br>1 ☐ Yes 2                           | use contribute to the cause of death?                                       |
| Division of Vital Records, | : The law requir<br>cete has been si<br>, page 2 should i   | Completed                     | CIRROHSIS OF  | LIVER   |  | 24a. Was an autopsy performed?                          | 24b. Were autopsy findings available prior to completion of cause of death? |
| ital                       |   | Be Co                         | 25. Was case referred to medical  |   |  | 1 ☐ Yes 2 ☑ No<br>ath (Check only one)                  | 1 Yes 2 No  |
| of V                       | hye<br>this   | 2                             | 1 Yes 2 No  | ospital: 1 Inpatient 2 □ ER<br>28a. Date of Injury 28   | Outpatient 3 DOA Other: 4 Nursing F<br>b. Time of 28c. Injury at                                 | dome 5 ☐ Residence<br>28d. Describe how inju            |   |
| ion                        | Attending r death.  c death.  ctor: After by the funer  | atlon                         | 1 Natural 5 Pending<br>2 Accident investigation   | (Month, Day Year)   | Injury Work?  M 1 ☐ Yes 2 ☐ No   |   |   |
| Divis                      | tal or Attending P s after death.  al Director: After i ad in by the funera   | Certification;                | 3 Suicide 6 Could not be 4 Homicide determined  | 28e. Place of Injury - At home building, etc. (Specify)   | , larm, street, factory, office  | 28l. Location (Street at<br>City or Town, State         | nd Number or Rural Route Number,<br>e)                                      |
|                            | To the Hospital or A within 24 hours after To the Funeral Director Completely filled in by  | edical                        | 29a. Certifier 1 Certifying Phys<br>(Check only 2 Medical Examination)  | ician: To the best of my knowle<br>ter: On the basis of examination<br>and manner stated.               | dge, death occurred at the time, date and plac<br>and/or investigation, in my opinion, death occ | e, and due to the cause(s<br>urred at the time, date an | and manner as stated.  d place, and due to the cause(s)                     |
|                            | To the within To the comple   | Me                            | 29b. Signature/and Aitle of certifier   | PHYSICIAN   | 29c. License number  |   | ate signed (Month, Day, Year) MBER 23 2005                                  |
| 2                          | 1   |                               | 30. Name and address of person who co   | mpleted cause of death (Item 23   | (Type, Print) 5401 OLD COV   | in Romo   | mp 21133'.  |
|                            | St<br>Regist  | ate<br>rar                    | 31. Date filed (Month, Day, Year) DEC 2 8 2   | 32. Registrar's Signature   |  |   |   |
| DH                         | MH 17 Rev 1/2   | _                             | 520202  | UUS Alakare   | S. Jark  |   |   |
|                            |   |                               |   |   | ORIGINAL   |   |   |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg-No 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Physician AGCEMBER 25 2005 1300 /Medical not institution, give street and number) 4c. County of Death 4h City Town or Location of Death Examiner BALTIMORE 8. Date of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security No 6 Sex 7. Age (In vrs. last birthday) **Funeral** Months Days Hours 1 ☐ M 2 🕶 F Yrs. Director Usual Residence of Decedent with the Maryland 10h Count 10d. Inside City Limits Town or Location 28a-f show ir than "natural", or items 23a or 28a-f ehov the Modical Examiner must be notified at 1 Yes 2 No Completed by Funeral Director none 10g. Citizen of What Country? 10f. Zip Code filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married 1 Tes 2 No Baltimore, Maryland 21215-0036 Specify. 3 ☐ Widowed 4 ☐ Divorced Holac 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) al Hygiene. ondary (0-12) College (1-4or 5+) Elementary/Se traumatic event, 7. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Pages 1 and 2 should be fill trent of Health and Mental H tant: If Item 27 is marked off Be ther 2 , MD 21229 if Health if Hem 27 I other tra Department of H Important: If Ites eny Injury or oth once. of Disposition Burial 2 Cremation 3 Removal from State 30/05 4 □ Donation 5 □ Other (Specify) 21. Signalars of Funeral Service 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying shock, or heart failure. List only one cause on each line. Approximate Interval Between Ooset and Death Immediate Cause (Final disease or condition resulting in death) SEPSIS Physician IND WEEKS /Medical Due to (or as a consequence of) Examiner RENAL Two YEARS STAGE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner iding physician and ise as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): 68760 Physician/Medical P.O. Box IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an autopsy performe Vital 1 ☐ Yes 2 No Hospital or Attending Physician: director, Be 25. Was case referred to medical examiner? 26. Place of Death | Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 1 Yes 2 No 1 npatient 2 ER/Outpatient 3 DOA ŏ this After thi 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Division 1 Natural 5 Pending М 1 Yes 2 No To the Hospital or Attenditional within 24 hours after death.

To the Funeral Director: A completely filled in by the fu investigation hours after death. 2 Accident 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 1 Contifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certified 29d. Date signed (Month, Day, Year) MESICAL ATTENSING 00059706 DECEMBER 25 2005

State Registrar

DHMH 17 Rev 1/2001

DEC 2 8 2005

ZAILAR I AG 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ALIYU, MS

32. Registrar's Signature

ORIGINAL

ST. AGNER HOSPITAL BALTIMORE, MIS

|   |                    | riease i  | State of Ma  |                 |   |                     |   |                                       |             | -egible.                   |                                      |
|---|--------------------|---|--|-----------------|---|---------------------|---|---------------------------------------|-------------|----------------------------|--------------------------------------|
|   |                    | 1 - For<br>State<br>Registrar   | Olato of Ma  | ar y larra      | Certifica   |                     |   |                                       | Reg. No.    | 005                        | 1815                                 |
|   |                    | Decedent's Name (First, Middle, Last)   |  |                 |   |                     |   | 2. Date of De                         | ath         |                            | 3. Time of Death                     |
| Physic  |                    | Margaret  | Klek   | 20              |   |                     |   | Decemb                                | er 21       | 2005                       | 9:00 AM                              |
| /Medi<br>Examir   |                    | 4a. Facility Name (If not Institution, give s   | treet and number)                                  |                 | 4b. Cit   | y, Town, or         | Location of Death                                   | )                                     |             | County of Dea              |                                      |
| LAGIIII   |                    | 641 Oldham  | Street   | +               | R   | alti                | more,   | MD                                    |             |                            |                                      |
| Funeral<br>Director   |                    | 5. Social Security Number 6. Sex 214-38-2554  | 7. Age   | 68 (In yrs. las | Yrs. If Und   | er 1 Year<br>s Days | if Under 24 Hrs.<br>Hours Min.                      | 8. Date of Bir<br>(Month, Di<br>12/22 | th<br>2/193 | 9. Bir<br>7 VA             | thplace (State or Foreign<br>buntry) |
| 9   |                    | Usual Residence of Decedent   |  | 10- 0-          | T   |                     |   |                                       |             |                            | 10d. Inside City Limits              |
| show  | _                  | 10a. State 10b. County  |  |                 | Town or Location  |                     |   |                                       |             |                            | 1 Say 2 □ No                         |
| 8a-1  | octo               |   |  | Daic            |   | . 0. 1-             |   |                                       | 10+ Citie   | on of Mhat C               |                                      |
| with th   | Dire               | 10e. Street and Number 641 Oldham Street  |  |                 |   | Zip Code            |   | 1                                     | -           | en of What Co<br>ed Sta    | -                                    |
| e 23  | erai               |   | 12. Was Decedent B                                 | Ever in U.S.    |   |                     | spanic Origin? (Si                                  | pecify Yes or No                      |             | 4. Race - Ame              |                                      |
| or Item   | y Funeral Director | 1 Never Married 2 Married   | Armed Forces? 1 ☐ Yes 2 ☑ N If Yes, Give           |                 |   | 2 No                | spanic Origin? (S)<br>n, Mexican, Puert<br>Specify: | o Rican, etc.)                        |             | Black, Whi<br>Specify: Whi | te, etc.                             |
| Nours<br>Nours  | d by               | 3 ☐ Widowed 4 ☑ vorced  | Year or Dates:                                     |                 | 10- DdN-11-   |                     |   |                                       |             |                            |                                      |
| be filed within 72 hours after death with the Maryland tal Hygiene. Id elygiene. Id other than "neturel", or Iteme 23e or 28e-1 show event, the Medical Exeminer must be redilled at  | Completed          | 15. Decedent's Edu<br>(Specify only highest grade<br>Elementary/Secondary (0-12)                            | cation<br>e co <i>mpleted)</i><br>College (1-4or 5 | (+)             | 16a. Decedent's Us<br>(Give kind of s<br>life. DO NOT<br>Domestic | vork done a         | luring most of wor                                  | king                                  |             | nd of Business<br>rate Ho  |                                      |
| permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any highry or other freumatic event, that Mane.  |                    | 17. Father's Name (First, Middle, Last)   |  |                 | Domescic  |                     | 18. Mother's Nan                                    | ne (First, Middle                     | , Maiden    | Sumame)                    |                                      |
| d be funtal h   | Be                 |   |  |                 |   |                     |   | e May Ad                              |             | ,                          |                                      |
| nark<br>mark  | ٦º                 | Louis Newby  19a, Informant's Name/Relationship (Ty   | pe, Print)   |                 | 19b. Mailing Addre  | ss (Street a        |   |                                       |             | Town, State,               | Zip Code)                            |
| d 2 s<br>d 2 s<br>d 4 s<br>d 4 s<br>d 4 s<br>d 5 s<br>d 5 s<br>d 5 s<br>d 6 s<br>d 6 s<br>d 6 s<br>d 6 s<br>d 6 s<br>d 6 s<br>d 6 s<br>d 6 s<br>d 6 s<br>d 6 s<br>d 6 s<br>d 6 s<br>d 6 s<br>d 6 s<br>d 6 s<br>d 6 s<br>d 6 s<br>d 6 s<br>d 6 s<br>d 6 s<br>d 6 s<br>d 6 s<br>d 6 s<br>d 6 s<br>d 6 s<br>d 6 s<br>d 6 s<br>d 6 s<br>d 6 s<br>d 6 s<br>d 6 s<br>d 6 s<br>d 6 s<br>d 6 s<br>d 6 s<br>d 6 s<br>d 6 s<br>d 6 s<br>d 6 s<br>d 6 s<br>d 6 s<br>d 6 s<br>d 6 s<br>d 6 s<br>d 6 s<br>d 6 s<br>d 6 s<br>d 6 s<br>d 6 s<br>d 6 s<br>d 6 s<br>d 7 s<br>d 7 s<br>d 7 s<br>d 7 s<br>d 7 s<br>d 6 s<br>d 7 s<br>d 7 s<br>d 7 s<br>d 7 s<br>d 7 s<br>d 7 s<br>d 7 s<br>d 7 s<br>d 7 s<br>d 6 s<br>d 7 s<br>d 7 s<br>d 7 s<br>d 7 s<br>d 7 s<br>d 7 s<br>d 7 s<br>d 7 s<br>d 7 s<br>d 7 s<br>d 7 s<br>d 7 s<br>d 7 s<br>d 7 s<br>d 7 s<br>d 7 s<br>d 7 s<br>d 7 s<br>d 7 s<br>d 7 s<br>d 7 s<br>d 7 s<br>d 7 s<br>d 7 s<br>d 7 s<br>d 7 s<br>d 7 s<br>d 7 s<br>d 7 s<br>d 7 s<br>d 7 s<br>d 7 s<br>d 7 s<br>d 7 s<br>d 7 s<br>d 7 s<br>d 7 s<br>d 7 s<br>d 7 s<br>d 7 s<br>d 7 s<br>d 7 s<br>d 7 s<br>d 7 s<br>d 7 s<br>d 7 s<br>d 7 s<br>d 7 s<br>d 7 s<br>d 7 s<br>d 7 s<br>d 7 s<br>d 7 s<br>d 7 s<br>d 7 s<br>d 7 s<br>d 7 s<br>d 7 s<br>d 7 s<br>d 7 s<br>d 7 s<br>d 7 s<br>d 7 s<br>d 6 s<br>d 7 s<br>d 7 s<br>d 7 s<br>d 7 s<br>d 7 s<br>d 7 s<br>d 7 s<br>d 7 s<br>d 7 s<br>d 7 s<br>d 7 s<br>d 7 s<br>d 7 s<br>d 7 s<br>d 7 s<br>d 7 s<br>d 7 s<br>d 7 s<br>d 7 s<br>d 7 s<br>d 7 s<br>d 7 s<br>d 7 s<br>d 7 s<br>d 7 s<br>d 7 s<br>d 7 s<br>d 7 s<br>d 7 s<br>d 7 s<br>d 7 s<br>d 7 s<br>d 7 s<br>d 7 s<br>d 7 s<br>d 7 s<br>d 7 s<br>d 7 s<br>d 7 s<br>d 7 s<br>d 7 s<br>d 7 s<br>d 7 s<br>d 7 s<br>d 7 s<br>d 7 s<br>d 7 s<br>d 7 s<br>d 7 s<br>d 7 s<br>d 7 s<br>d 7 s<br>d 7 s<br>d 7 s<br>d 7 s<br>d 7 s<br>d 7 s<br>d 7 s<br>d 7 s<br>d 7 s<br>d 7 s<br>d 7 s<br>d 7 s<br>d 7 s<br>d 7 s<br>d 7 s<br>d 7 s<br>d 7 s<br>d 7 s<br>d 7 s<br>d 7 s<br>d 7 s<br>d 7 s<br>d 7 s<br>d 7 s<br>d 7 s<br>d 7 s<br>d 7 s<br>d 7 s<br>d 7 s<br>d 7 s<br>d 7 s<br>d 7 s<br>d 7 s<br>d 7 s<br>d 7 s<br>d 7 s<br>d 7 s<br>d 7 s<br>d 7 s<br>d 7 s<br>d 7 s<br>d 7 s<br>d 7 s<br>d 7 s<br>d 7 s<br>d 7 s<br>d 7 s<br>d 7 s<br>d 7 s<br>d 7 s<br>d 7 s<br>d 7 s<br>d 7 s<br>d 7 s<br>d 7 s<br>d 7 s<br>d 7 s<br>d 7 s<br>d 7 s<br>d 7 s<br>d 7 s<br>d 7 s<br>d 7 s<br>d 7 s<br>d 7 s<br>d 7 s<br>d 7 s<br>d 7 s<br>d 7 s<br>d 7 s<br>d 7 s<br>d 7 s<br>d 7 s<br>d 7 s<br>d 7 s<br>d 7 s<br>d 7 s<br>d 7 s<br>d 7 s<br>d 7 s<br>d 7 s<br>d 7 s<br>d 7 s<br>d 7 s<br>d 7 s<br>d 7 s<br>d 7 s<br>d 7 s<br>d 7 s<br>d 7 s<br>d 7 s<br>d 7 s<br>d 7 s<br>d 7 s<br>d 7 s<br>d 7 s<br>d 7 s<br>d 7 s<br>d 7 s<br>d 7 s<br>d 7 s<br>d 7 s<br>d 7 s<br>d 7 s<br>d 7 s<br>d 7 s<br>d 7 s<br>d 7 s<br>d 7 s<br>d 7 s<br>d 7 s<br>d 7 s<br>d 7 s<br>d 7 s<br>d 7 s<br>d 7 s<br>d 7 s<br>d 7 s<br>d 7 s<br>d 7 s<br>d 7 s<br>d 7 s<br>d 7 s<br>d 7 s<br>d 7 s<br>d 7 s<br>d 7 s<br>d 7 s<br>d 7 s<br>d 7 s<br>d 7 s<br>d 7 s<br>d 7 s<br>d 7 s<br>d 7 s<br>d 7 s<br>d 7 s<br>d 7 s<br>d 7 s<br>d 7 s<br>d 6 s<br>d 7 s<br>d 6 s<br>d 7 s<br>d 6 s<br>d 7 s<br>d 6 s<br>d 7 s<br>d 6 s<br>d 7 s<br>d 6 s |                    | Frank Young, Sr./Ca   |  |                 | 641 Oldh  |                     |   |                                       |             |                            |                                      |
| Te, IV I and Health tem 27  |                    | 20a. Method of Disposition  |  | 20b. Pla        | ce of Disposition (N  | lame of             | a)  | Date<br>Dec 31                        | 20c. Lo     | cation - City or           | Town, State                          |
| t. Pages<br>timent of l<br>rant: If ite   |                    | 1  Burial 2  Cremation 3  F  1  Other (Specify)   | emoval from State                                  |                 | nity Ceme   |                     | 0)  | 2005                                  | Balt        | imore,                     | Maryland                             |
| nit. F<br>artme<br>ortan<br>injur   |                    | 21. Signature of Funeral Service Licens   | 99   |                 | 22. Name  | and Addres          | s of Facility                                       | 1 Alter                               | ative       | ve                         |                                      |
| Depariment of the part of the   |                    | B. O. Dung Rit  | to Me  | 144             | 1.10000000 1/1000   |                     |   |                                       |             |                            | ryland 21286-                        |
|   |                    | 23a. Part1. Priter the disease, or complishock, or heart failure. List only or                              |  |                 |   | ode of dyin         | g, such as cardiad                                  | or respiratory a                      | arrest,     |                            | Approximate<br>Interval Between      |
| Physician   |                    | Immediate Cause (Final  | M o la   | clat            |   |                     | e can   |                                       |             |                            | Onset and Death                      |
| /Medical  |                    | disease or condition resulting in death)  | Due to (or as                                      | a conseque      |   | JULY                | e Carl  | iei                                   |             |                            |                                      |
| Examiner  |                    |   |  |                 |   |                     |   |                                       |             |                            |                                      |
|   | je                 | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | Due to (or as                                      | a conseque      | ence of):   |                     |   |                                       |             |                            |                                      |
| cuted<br>nd<br>ransit   | Examiner           | that initiated events   | o  |                 |   |                     |   |                                       |             |                            |                                      |
| rou, le be executed ysician and e burial-transit  |                    | resulting in death) Last  | Due to (or as                                      | a conseque      | ence of):   |                     |   |                                       |             |                            |                                      |
| ate be<br>aysici  | Icai               |   | đ  |                 |   |                     |   |                                       |             |                            |                                      |
| artifical<br>ing phy<br>e as th   | Med                | IF FEMALE:  |  |                 |   |                     |   |                                       |             |                            | L                                    |
| ath cer<br>ttendir<br>or use  | by Physician/Medi  | 23b. Was decedent pregnant in the past 12 months?   | 23c. If yes, outcome<br>1☐Live birth               | 2 Fetal c       | leath 3 Ectopic   |                     |   |                                       | 2           | 3d. Date of de!<br>Month   | livery<br>Day Year                   |
| the a   | /sic               | 1 ☐ Yes 2 █ No<br>9 ☐ Unknown   | 4□Pregnant at<br>9□Unknown                         | time of dea     | ith 5 ☐ Other   | (ѕреспу)            |   |                                       |             |                            |                                      |
| hat the bd by detac   | Ph                 | Part II. Other significant conditions co.   | ntributing to death b                              | ut not result   | ting in the underlying  | a cause give        | en in Part I.                                       | 23e. Did                              | tobacco u   | se contribute t            | o the cause of death?                |
| I HECOICAS, P.O. BOX 001  The law requires that the death certificate ate has been signed by the attending physpage 2 should be detached for use as the   |                    |   |  |                 |   |                     |   | 1 🗆                                   | Yes 2       | No 3□P                     | robably 4. Onknown                   |
| necords,<br>he law requires<br>e has been sign<br>ige 2 should be   | Completed          |   |  |                 |   |                     |   | 24a. Was                              | s an        | 24h Were a                 | utopsy findings available            |
| has<br>bas  | ш                  |   |  |                 |   | <u>-</u> -          |   | auto                                  |             | prior to death?            | completion of cause of               |
| r: Th   |                    |   |  |                 |   |                     |   |                                       | 2 🗆 No      | 1 🗆 Yes                    | s 2 No                               |
| VICAL  Nicien: T  certificat rector, pa   | Be                 | 25. Was case referred to medical examiner?  | Hospital:  | 205             | R/Outpatient 3  | DOA Othi            | 26. Place of Dea                                    |                                       |             | Other (Co.                 | 2016.1                               |
| Phys rithis   | 15                 | 1 Yes 2 No  | 1 Inpatie  | iry 2           | R/Outpatient 3 28b. Time of                                       | 28c. Injun<br>Worl  |   | lome Res<br>28d. Describe             |             |                            | gcity)                               |
| ding<br>ding<br>h. Afte   | tion               | 1 Natural 5 ☐ Pending<br>2 ☐ Accident investigation   | (Month, Da)  | y Year)         | Injury<br>M   |                     | k?<br>Yes 2 ∐No                                     |                                       |             |                            |                                      |
| r Attending or death.   | ertification:      | 3 ☐ Suicide 6 ☐ Could not be  | 28e. Place of Inj                                  | ury - At hon    | ne, farm, street, fact  | ory, office         |   | 28f. Location                         | (Street and | d Number or A              | lural Route Number,                  |
| after<br>Dire   | ert                | 4 Homicide  | building, etc                                      | c. (Specify)    |   |                     |   | City or 10                            | iwn, State, | ,                          |                                      |
| UNISION OI VIIBI HER<br>To the Hospitel or Attending Phyeicien: The lav<br>within 24 hours after death.<br>To the Funerel Director: After this certificate has<br>completely filled in by the funeral director, page 2  | Salc               |   | sician: To the best                                |                 |   |                     |   |                                       |             |                            |                                      |
| he Hin 24<br>he Fu<br>pletel  | edical             | (Check only 2 Medical Exami   | iner: On the basis of<br>and manner sta            |                 | on and/or investigat  | on, miny o          | pillion, usath occi                                 | arou at the time                      |             |                            |                                      |
| To the within 2 To the complet  | Σ                  | 29b. Signature and title of certifier   |  |                 |   | 29c. Licensi        | e number  | . 0                                   |             | e signed (Mon              |                                      |
| 2   |                    | Hans  | is M   | 1               |   | _り(                 | 20634   | ty                                    | Decei       | where 3                    | Ne, 2005                             |
| 2   |                    | 30. Name and address of person who c  | ompleted cause of d                                | death (Item :   |   |                     |   |                                       | , 1         |                            |                                      |
| 0   |                    | 4940 Easter   | 1 Aven   | lle             | Balby   | nove                | MD  | 2122                                  | T           |                            |                                      |
| S   | tate               | 31. Date filed (Month, Day, Year)   | 005 32. Radistr                                    | ar's Signatu    | TO SEA  | 1                   |   |                                       |             |                            |                                      |

|                |  |                     | For<br>State<br>Registrar  | State of M   | aryland / Depa<br><i>Ce</i> a                              | artment of<br>rtificate of                                 |                                      | _   | giene                               | 5 4  | 1816  |
|----------------|--|---------------------|--|--|--|--|--------------------------------------|---|-------------------------------------|--|---|
|                | Physici  |                     | 1. Decedent's Name (First, Middle, Last) Stefania  | Kul  | yk   |  |                                      | 2. Date of De<br>Month<br>Decemb              | per 20.                             | 2 <sup>Y</sup> 0 <sup>a</sup> r <sub>0</sub> 5 9 | Time of Death                                 |
|                | /Medic<br>Examin   |                     | 4a. Facility Name (If not institution, give Johns Hopkins-W  | street and number)   |  | 4b. City, Town,<br>Baltim                                  | or Location of De                    |   | 4c. County                          | of Death   | t   |
|                | Funeral<br>Director  |                     | 5. Social Security Number 6. Security Number 15. Social Security Number 15. Security N | 7. Ag  | ge (In yrs. last birthday)<br>63 Yrs.                      | If Under 1 Year<br>Months Days                             |                                      | 8. Date of Bir<br>n. Dec I                    | u Vaari                             | 9. Birthplace<br>Country)<br>Polan               | (State or Foreign                             |
|                | be filed within 72 hours after death with the Maryland that Hygiene. Id other then "natural", or items 23e or 28a-f show event, it a Madical Examinational banailised at | ٥٢.                 | Usual Residence of Decedent  10a. State 10b. County  |  | 10c. City, Town or Lo                                      |  |                                      |   |                                     |  | Inside City Limits                            |
|                |  | Directo             | MD N/ 10e. Street and Number 2313 Eastern Av   |  | Baltimo  | 10f. Zip Code<br>2122                                      | /1                                   |   | 10g. Citizen of W                   |  |   |
| 036            |  | by Funeral Director |  | 12. Was Decedent Armed Forces? 1  Yes 2  If Yes, Give Year or Dates: | No   | Was Decedent of  | Hispanic Origin?<br>ban, Mexican, Pu | (Specify Yes or No<br>erto Rican, etc.)       | o- 14. Race<br>Blac                 | American Ir<br>k, White, etc.<br>White           |   |
| 21215-0036     |  | Completed           | 15. Decedent's Edu<br>(Specify only highest grade<br>Elementary/Secondary (0-12)   |  | (Give  | dent's Usual Occu<br>kind of work done<br>DO NOT use retin | e during most of w<br>ed)            | vorking                                       | 16b. Kind of Bu                     |  |   |
| Maryland 2     | be filed<br>tal Hygi<br>d other<br>event,  | To Be Co            | 17. Father's Name (First, Middle, Last) Stefan Ferlejko  |  | 1 4  |  | 18. Mother's N                       | <sub>ame (First, Middle,</sub><br>nknown      |                                     |  | 100   |
| altimore, Mary | iges 1 and 2 and 2 and 2 and 2 and 2 and 2 and 27 is   |                     | 19a. Informant's Name/Relationship (Ty $ \underbrace{Michael \ Kulyk-S}_{\text{20a. Method of Disposition}} $  | on   | 2313   | Easter   | n Ave.                               | Baltimo                                       | ore MD                              | 21224<br>City or Town,                           | 4   |
| Baltim         | permit. Pag<br>Department<br>Importent: I<br>eny injury o<br>once.   |                     | 4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service License   | 99   | 22   | 2. Name and Addr   | ress of Facility K a                 | czorows<br>et Balt                            | Dundal<br>ski Fun                   | eral I   | Home, PA                                      |
| 8760,          | Medical Examiner bulyaician and bulyaician and bulyaician streams it is the buriat-transit   | dicai Examiner      | 23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  | Due to (or as  | a consequence of): a consequence of): a consequence of):   |  |                                      | ac or respiratory a                           | /                                   | Inte   | oroximate sorval Between sat and Death works. |
| .O. Box 6      | The law requires that the death certific<br>ite has been signed by the attending p<br>page 2 should be detached for use as   | Physician/Me        | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 MNo 9 □ Unknown   | 3c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a' 9 ☐ Unknown       | 2 Fetal death 3  | Ectopic pregnant   | су                                   |   | 23d. Date<br>Mor                    | e of delivery<br>oth Day                         | Year  |
| ٥.             | quires that t<br>n signed by<br>uld be deta  | by                  | Part II. Other significant conditions cor  | ntributing to death b  | out not resulting in the u                                 | nderlying cause g  | iven in Part I.                      |   | obacco use contr<br>Yes 2 No        |  |   |
| i Records,     |  | Completed           |  |  |  |  |                                      | 24a. Was<br>autor<br>perfo<br>1 \( \text{Yes} | psy pormed? d                       | Vere autopsy frior to complete eath?             | indings available<br>tion of cause of<br>No   |
| Vital          | Physicien: Th<br>this certificate<br>ral director, pag   | Be                  | 25. Was case referred to medical examiner?   | lospital:  |  |  | thor                                 | eath (Check only o                            |                                     |  |   |
| of             | nding Phys<br>th.<br>: After this<br>e funeral di  | tion: To            | 1 Yes 2\(\Sigma\) No  27. Manner of Death  1 \(\Sigma\) Natural 2 \(\Delta\) Accident  1 \(\Sigma\) Nestigation  | 1 ☐ Inpatie  28a. Date of Inju (Month, Da                            | ıry 28b. Time o  | 28c. Inju  | 4 [                                  | 1 28d. Describe                               | dence 6 ⊡Othe<br>how injury occurre |  |   |
| Division       | To the Hospital or Attending within 24 hours after death.  To the Funerel Director: After completely filled in by the fune.  | Certification:      | 3 Suicide 6 Could not be determined  | 28e. Place of Inj<br>building, et                                    | ury - At home, farm, str<br>c. (Specify)                   |  |                                      |   | Street and Numbe<br>wn, State)      | or Aural Rou                                     | ute Number,                                   |
|                | To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by   | edicai              | (Check only 2 Medicel Exemi-   | sicien: To the best<br>ner: On the basis o<br>and manner st          | of my knowledge, deat<br>of examination and/or in<br>ated. | vestigation, in my   | opinion, death oc                    | curred at the time,                           | date and place, a                   | nd due to the                                    | cause(s)                                      |
|                | Vith<br>To I   | Σ                   | 29b. Signature and title of certifier  | 1  | 2/120  |  | se number                            |   | 29d. Date signed                    |  |   |
|                | 7  |                     | 30. Name and address of person who con Gracito V. Patr   | ompleted cause of c  | leath (Item 23a) (Type.                                    | Print)   | 08358                                | Rol+im  |                                     |  | , 2005  |
|                | Sta<br>Registr   | _                   | 31. Date filed (Month, Day, Year) DEC 2 8 2005   |  | rar's Signature  |  | .u KUAU                              | ратсти  | ore, Mo                             | . 212  | J4  |

|                     |   |                | State of Maryland /  1- State Registra Amend Item #31 Per DVR G850  | / Depa                | artment of H  | lealth and         | Mental Hyg                             | _  | 41817  |  |
|---------------------|---|----------------|---|-----------------------|---|--------------------|--|--|--|--|
|                     | Physicia  | 20             | 1. Decedent's Name (First, Middle, Last)  |                       | <u> </u>  |                    | 2. Date of Deat                        | Day Year   | 3. Time of Death                                   |  |
| 1                   | /Medic  | al             | ANNA MARINOS KOLTOS   |                       |   |                    | DEC. 22                                | , 2005   | 8:00 PM  |  |
| d.                  | Examin  | er             | 4a. Facility Name (If not institution, give street and number) FUTURE CARE  |                       | 4b. City, Town, or Location of Death BALTIMORE            |                    |  | 4c. County of Death  |  |  |
|                     | Funeral   |                | 5. Social Security Number 6. Sex 7. Age (In yrs. last   | birthday)             | If Under 1 Year   | If Under 24 Hrs    | s. 8. Date of Birth                    | 9 Birth  | place (State or Foreign                            |  |
|                     | Director  |                | 101-18-3219 <sup>1□M 2</sup> √ F 86   | Yrs.                  | Months Days   | Hours Min          | SEPT . 20                              | ), 1919  | PA.  |  |
|                     | land  |                | Usual Residence of Decedent  10a. State 10b. County 10c. City, To   | own or Lo             | cation  |                    |  |  | 10d. Inside City Limits                            |  |
|                     | Mary<br>a-f sh  | tor            | MD. N/A B.  | ALTI                  | MORE  |                    |  |  | 1 Tyes 2 □ No                                      |  |
|                     | or 28s  | Director       | 10e. Street and Number  |                       | 10f. Zip Code   |                    |  | 10g. Citizen of What Country?  |  |  |
|                     | sath w  | erai           | 820 UMBRA STREET  11 Marital Status 12. Was Decedent Ever in U.S.   | 12.1                  | Mac Decedent of h   | 21224              |  | JNITED STAT  |  |  |
| 36                  | permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent; If item 27 is marked other than "naturel", or Items 23e or 28e-f show any injury or other treumetic event, Ite Madical Examiner must be notified at ODGE. | by Funeral     | 11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 Yes 2 No If Yes, Give Year or Dates:                        | -                     | was Decedent of r<br>f Yes, specify Cub<br>1 ☐ Yes 2 🗓 No |                    | Specify Yes or No-<br>rto Rican, etc.) | Black, White   | , etc.   |  |
| 2-0                 | 72 ho   | eted           | 15. Decedent's Education (Specify only highest grade completed)   | (Give                 | dent's Usual Occup  | during most of wo  | orking                                 | 16b. Kind of Business/Ir   | ndustry  |  |
| 121                 | within<br>ane.<br>than "  | Completed      | Elementary/Secondary (0-12) College (1-4or 5+)  |                       | DO NOT use retire<br>BLY LINE                             | •                  |  | MANUFACTUR   | TNG CO   |  |
| <u>q</u>            | be filed value Hygie od other levent, II  | Be Co          | 17. Father's Name (First, Middle, Last)   | DDLIII                | DET ETHE  |                    | ame (First, Middle, A                  |  | 1110 00.   |  |
| /lan                | Wental<br>Wental<br>wrked   | To B           | NICK MARINOS  |                       |   | DESPINA            | A MIMIDIS                              |  |  |  |
| Maryland 21215-0036 | nd 2 sho<br>alth and I<br>27 is me<br>r treume  |                | 19a. Informant's Name/Relationship (Type, Print) ANGELINE BASIL   |                       |   |                    |  | City or Town, State, Zi  |  |  |
| Baltimore,          | es 1 a of Hez titem   |                | 1 M Busial 2 Commetica 2 D Romaval from State Ceme  | stery, cren           | sition (Name of<br>matory or other pla                    | се)                |  | 20c. Location - City or T  |  |  |
| Ē                   | Page<br>Iment<br>Ient; I  |                | '4 □Donation 5 □ Other (Specify) UAK  |                       | CEMETERY  |                    |  | BALTIMORE,   |  |  |
| Bal                 | permit<br>Depart<br>Impor<br>any in   |                | 21. Signature of Funeral Service Licensee   | (                     |   | TERN AVE.          | , BALTIMO                              | S. ZEILER &<br>DRE, MARYLA   |  |  |
|                     | Physician   |                | 23a. Part1. Enter the disease, or complications that caused the death. I shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition | M. an                 | t .   | ng, such as cardia | ac or respiratory arre                 | est,   | Approximate<br>Interval Between<br>Onset and Death |  |
|                     | /Medical<br>Examiner  |                | resulting in death)  Due to (or as a consequence)   | ce of):               | •   |                    |  |  |  |  |
|                     | sit s   | iner           | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events   | ce of):               |   |                    |  |  | <u> </u>   |  |
| oʻ                  | ate be executed<br>nysician and<br>he burial-transit  | Examiner       | that initiated events resulting in death) Last C. Due to (or as a consequence   | ce of):               |   |                    |  |  |  |  |
| 68760,              | cate be<br>physici<br>the bu  | dical          | d   |                       |   |                    |  |  |  |  |
| .O. Box 6           | The law requires that the death certifica<br>sie has been signed by the attending ph<br>page 2 should be detached for use as th   | Physiclan/Med  | IF FEMALE:  23b. Was decedent pregnant in the past 12 months:  1 ☐ Yes 2 ☐ Mo 9 ☐ Unknown  23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 9 ☐ Unknown         | ath 3                 | Ectopic pregnanc  | у                  |  | 23d. Date of deliv<br>Month  | ery<br>Day Year                                    |  |
| Records, P.         | uires that<br>signed by   | by             | Part II. Other significant conditions contributing to death but not resultin  | g in the ui           | nderlying cause gr  | ven in Part I.     | 23e. Did tob                           | acco use contribute to   | the cause of death?                                |  |
| O<br>O              | aw requires been si   | plete          | Gastroesarhard Rething  | son                   | ,   |                    | 24a. Was ar                            | 24b. Were aut  | opsy findings available ompletion of cause of      |  |
| _                   | The tate has page   | Completed      | Dearessan Perinberal  | Vasi                  | who D. Se   | ese                | autops<br>perform<br>1 Yes 2           | ned/ death?  | _  |  |
| Vital               | icien:<br>sertific<br>ector,  | Be             | 25. Was case referred to medical examiner?  |                       | 0#  |                    | eath (Check only on                    | 9)   |  |  |
|                     | Attending Physicien: or death. sctor: After this certification in the funeral director.   | To :           | To res 2 pro  | Outpatien  b. Time of | II 3 DOA  |                    | Home 5 Reside                          | nce 6 Other (Special of Incidental of Incide | fy)  |  |
| 0                   | nding<br>ath.<br>r: Afte<br>e fune  | atior          | 1 ☐ Matural 5 ☐ Pending (Month, Day Year) 2 ☐ Accident investigation  | Injury                | Wo  | rk?<br> Yes 2□No   |  |  |  |  |
| Division of         | or Atterater de Directo   | Certification: | 3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home building, etc. (Specify)  | , farm, str           | eet, factory, office                                      |                    | 28f. Location (St.<br>City or Town     | reet and Number or Rur<br>, State)   | al Route Number,                                   |  |
|                     | To the Hospitel or Attending Physicien: The law within 24 hours after death.  To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2  | edical C       | 29a. Certifier (Check only one)  1 Vertifying Physician: To the best of my knowler of my knowler one)  2 Medical Examiner: On the best of examination and manner stated.        |                       |   |                    |  |  |  |  |
|                     | To the within To the comple   | Me             | 29b. Signature and title of certifier   | //                    | 29c. Licens   | se number          | 29                                     | 9d. Date signed (Month,  | Day, Year)   |  |
|                     |   |                |   | //                    | 170   | 06263              | 8                                      | 12/43/05   |  |  |
|                     | V   |                | 30. Name and address of person who completed cause of death (Item 23  | a) (Type,             | Print)  | Hela.              | C+ (                                   | 40 1 R 1J.   | 11/11/11/11  |  |
|                     | Sta   | te             | 31. Date filed (Mooth, Day, Year) 32. Registrar's Signature   | V.(                   | 0, 780  | - MASEL            | 121, Ju                                | TE A WITH  | in withthe   |  |
|                     | Registr   |                | 12/23/05 DEC 2 8 2005   | Maria                 | W.  | harte              |  |  |  |  |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State Amend Item #12&18 Per FH G850 1119 216/85 Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Robert Clifford 2005 6:05 Logue Dec /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner If Under 24 Hrs. 8. Date of Birth (Month, Day, April 2 Kline Hospice House Mt. Airy Frederick If Under 1 Year Months Days 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 🕱 M 2 🗆 F Director 218-30-8402 70 Maryland Usual Residence of Decedent 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits iteme 23a or 28e-f ehow the Medical Examiner must be notified at 1 ☐ Yes 2 🗓 No Be Completed by Funeral Director Carroll Mt. Airy 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 4928 Ridge Road 21771 US filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 152 A. No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Specify. White 3 Widowed 4 Divorced 'naturel', 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry at Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Small Business Owner welding & equipment . Peges 1 and 2 should be filed w tment of Health and Mental Hygien tent: If item 27 ie marked other ti jury or other traumatic event, IL 18. Mother's Name (First, Middle, Maiden Sumame)
Carrie Myrle Ogg 17. Father's Name (First, Middle, Last) ၉ Shirley Anne Burdette Logue Wilford Logue 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4928 Ridge Road Mt. Airy, MD 21771 Shirley Logue wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Dec 27 2005 Winfield, MD permit. Pege Depertment of Important: If any Injury or South Carroll Crematory 4 Denation 5 ☐ Other (Specify) 22. Name and Address of Facility
Burrier-Queen Funeral Home and Crematory
1212 W. Old Liberty Road Winfield, MD 21 21. Signature of Funeral Service Licensee 1) an 234. Part I Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death mmediate Cause (Final disease or condition resulting in death) Physician (see /Medical Examiner thesdevok Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by (erbrail 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 1 ☐ Yes 2 ☐ No vas 2 No of Vital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 1050100 1 Yes 2 No Other: Nursing/Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA Certification: To ctor: After this y the funeral o Harri 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Natural 5 Pending investigation within 24 hours efter death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 THomicide 1 Coffifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier) 29d. Date signed (Month, Day, Year)

Registrar

State

30. Name and address of person who con

av 31. Date filed (Month, Day, Year)

DEC 2 8 2005

Maryland 21215-0036

Box 68760,

Division

1502 Samain

cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

|                     |   |                     | State of Maryland / Department of Health and Mental Hygiene 1,23a per Dr. G850 12/28/05dbb Registrar Processing 1,23a per Dr. G850 12/28/05dbb Registrar  |
|---------------------|---|---------------------|---|
|                     | Physici   | an                  | 1. Decedent's Name (First, Middle, Last)  Thomas Lockemy Sr.  2. Date of Death Month Day Year 3. Time of Death December 16 2001 3:10 PM   |
|                     | /Medic<br>Examin  |                     | 4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death  4c. County of Death   |
|                     | Funeral   |                     | Iniversit of Maryland Marical (Anter Saltimure MD)  5. Social Security Number 6. Sex 17. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 247-88-0788 10 M 2 F 7. Age (In yrs. last birthday) Months Days Hours Min. (Month, Day Year) 247-88-0788   |
|                     | Director  |                     | 247-88-0788 12 M 2 F 56 Yrs. Months Days Hours Min. 5-3-49 Scountry Survey Survey States of Decedent  |
|                     | ryland<br>how   |                     | 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits  |
|                     | the Ma<br>28a-f s   | ecto                | DUNCALK    Yes 2   No   |
| 336                 | 23a or  | rai Di              | 7239 Martell Ave. 21222 U.S.A.  |
|                     | s 1 and 2 should be filed within 72 hours after deeth with the Maryland f Health and Mental Hygiene. Item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at | by Funeral Director | 11. Marital Status  1 Never Married 2 Married  3 Widowed Appivorced  12. Was Decedent Ever in U.S. Amed Forces?  1 Never Married 2 Married  3 Widowed Appivorced  13. Was Decedent of Hispanic Origin? (Specify Yes or No-lift Yes, specify Cuban, Mexican, Puerto Rican, etc.)  14. Race - American Indian, Black, White, etc.  1 Yes 2 No Specify:  SpecifyWhite  |
| Maryland 21215-0036 | within 72 ho<br>ane.<br>than "natur<br>ne Medical I   | Completed           | 15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  8th  16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)  HVAC Mechanic  HVAC   |
| d 2                 | be filed within tal Hygiene.<br>d other than "  | Be Co               | 17. Father's Name (First, Middle, Last)  18. Mother's Name (First, Middle, Maiden Sumame)   |
| rylaı               | 2 should be<br>and Mental<br>is markad<br>is markad   | Tof                 | Lacey Golman Lockemy  Virginia Burr  19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  |
|                     | l and 2 sl<br>fealth an<br>im 27 is r<br>har traur  |                     | Diane Ulrich (Friend)  7239 Martell Ave. Bato. MD 21222   |
| Baltimore,          | 9 = 5   | 10                  | 20a. Method of Disposition  1 \( \text{Z8}\) urial 2 \( \text{Cremation} \) 3 \( \text{Removal from State} \)  1 \( \text{Donation} \) 5 \( \text{Other} \) (Specify)  20b. Place of Disposition (Name of cemetery, crematory or other place) Bohemian  20c. Location - City or Town, State Rosedale  |
| Balt                | permit. Pa<br>Departmen<br>Important:<br>any injury<br>once.  |                     | 21. Signature of Funeral Service Licensee  22. Name and Address of Facility Wesley Chavis Jr. FH 2007 Eastern Ave, Balto. MD 21231  |
|                     | Physician<br>/Medical<br>Examiner   | er                  | 23a. Pack Enter the disease, complications that cause is death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Let only one cause on each ine.  End Stage Renal Disease  Complications that cause is death. Do not enter the mode of dying, such as cardiac or respiratory arrest, interval Between Onset and Death  Disease  Du L (or as a consequence of):  Sequentially list conditions, if any, leading to immediate  Due to (or as a consequence of):   |
| 68760,              | death certificate be executed<br>e attending physician and<br>nd for use as the burial-transit  | edical Examiner     | if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last  Due to (or as a consequence of):  C. Due to (or as a consequence of):  d   |
| .O. Box             | that the death certific<br>ed by the attending p<br>detached for use as i   | Physician/Me        | FFMALE: 23b. Was decedent pregnant in the past 12 months?   1   Yes   2   No   9   Unknown   23c. If yes, outcome of pregnancy   1   Live birth   2   Fetal death   3   Ectopic pregnancy   3   Ectopic pregnancy   Month   Day   Year   | rds, P              | sign<br>d be  | by.                 | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause of death?  1 Yes 2 No 3 Probably 4 Durknown  |
| I Records           | The law<br>ate has b<br>page 2 sl   | Completed           | Coronar Arter Distante  24a. Was an autopsy prior to completion of cause of death?  1 Yes 2 12 No  24b. Were autopsy findings available prior to completion of cause of death?  1 Yes 2 12 No   |
| Vital               | Physician: Th<br>this certificate<br>ral director, pag  | o Be                | 25. Was case referred to medical examiner?  1   |
| n of                |   | lon: T              | 27. Manner of Death  1 Natural 5 Pending  28a. Date of Injury (Month, Day Year)  28b. Time of linjury at Work?  28d. Describe how injury occurred Work?   |
| Division            | ten<br>leat<br>lor:<br>the  | Certification:      | 2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, c. (Specify)  28f. Location (Street and Number or Rural Route Number, City or Town, State)   |
|                     | Hospita<br>4 hours<br>Funaral<br>ely fillec   | edical C            | 29a. Certifier  (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  2 Medical Examiner: Op the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |
|                     | To the h<br>within 2.<br>To the I   | M                   | 29b. Signature and file of certifier 29c. License number P18926 29d. Date signed (Month, Day, Year)   |
| (                   | 6   |                     | 30. Name id address i erson who completed cause of death (Item 23a) (Type, Print)  22 5. Green St. Baltimure MD 2126) Shahowa Kelishadi MD  |
|                     |   |                     | 21 Date filed (Month Day Your) # 20 Deviation's Circulus  |
|                     | Sta<br>Registr  |                     | 31. Date filed (Month, Day, Year)  DEC 2 8 2005  32. Registrar's Signature  |

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 12725/2085 0500 Margaret Ann Loftice /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frederick 1820 Latham Drive Frederick If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 9. Birthplace (State or Foreign Country) Maryland 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 1□ M 2 F 1077571914 213-09-5422 91 Director Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other then "naturel", or itema 23a or 28a-f show traumatic svent, the Madical Examinar must be notified at 1 ☐ Yes 2 No Director Maryland Frederick Frederick 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 1820 Latham Drive 21701 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after one of Health and Mental Hygiene. Int: If item 27 is marked other then "naturel", or item 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White Specify: Completed by 3 Widowed 4 □ Divorced Year or Dates: 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Seamstress Clothing 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Thomas Richard Costin Mary Catherine Dobbin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) J. Cameron Crimes - Son 6 Cypress Trail SW Fairfield, PA 17320-8485 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 M Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) permit. Page Department of Important: If Bayview Crematory 12/29/2005 Baltimore, Maryland 21. Signature of Funeral Service Licenses David J. Wober Funeral Homes P.A. 5311 Edmondson Avenue Baltimore, Maryland 21229 any in Varne much 23a. Part1. Enter the dise set or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in dealh) Physician N WEEK Dreumonia /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) he 9 Unknown Š cate has been signed page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ğ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death? DISPOSE certificate 1 Yes 2 No 2 🗷 No 25. Was case referred to medical examiner? funeral director. Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) ASSISTED 1 Yes 2 No Certification: To 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of After Natural 5 Pending Facility 1 Yes 2 No 2 Accident the Funeral Director; 6 Could not be determined 3 ☐ Suicide 28e. Place ol Injury - At home, farm, street, factory, office building, etc. (Specify) 28l. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical Examiner: On the bast of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 24 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Shah Hiran, mn 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Shah Thurson Hron Thomas 31. Date filed (Month, Day, Year) 32. State 8 2005 Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician**  $A^{\ M}$ 23, December 2005 6:00 Norbert G. Loos /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Silver Spring

If Under 1 Year | If Under 24 Hrs.

Months Days | Hours | Min. Montgomery Springbrook Adventist Nursing Home 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Hours 1**∑**M 2□F 81 Yrs. Director 144-16-4727 June 28, 1924 New Jersey Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits th and Mental Hygiene. 27 is marked other than "neturel", or items 23a or 28a-f ehow traumatic event, the Medical Examinar must be notified at 10a. State 10b. County 1 ☐ Yes 2 X No Maryland Montgomery Silver Spring Direc 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with 311-B 20904 United States 531 Randolph Road Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 XYes 2 DNo 1943 - tryes, Give Year or Dates: 1946 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ges 1 and 2 should be filed within 72 hours after it of Health and Mental Hygiene.
If item 27 Is marked other than "neturel", or Ite 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No White Specify: ۵ Specify: 3 XWidowed 4 Divorced Completed 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Interior Designer Interior Design 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ethel E. Adams George J. Loos ပ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pamela Loos-Noji/daughter 1341 Hemlock Street, NW, Washington, DC January 5, 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Pages Franklin Menorial Park 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State permit. Page Department of Importent: If eny Injury or once. North Brunswick, New Jersey 2006 4 ☐ Donation 5 ☐ Other (Specify) Crematorium 21. Signature of Funeral Service Litensee 22. Name and Address of Facility
Kobert A. Pumphrey Funeral Home, Bethesda—Chevy Chase, Inc
7557 Wisconsin Avenue, Bethesda, Maryland 20814 William a. Honghes M01173 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Atherosclerotic Cardiovascular Disease /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-tran Due to (or as a consequence of) physician s the burial P.O. Box 68760 Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4 Pregnant at time of death 5 Other (specify) cate has been signed by the page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ۾ Diabetes Mellitus, End Stage Renal Disease, 2 X No 3 ☐ Probably 4 ☐ Unknown Be Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? Malnutrition autopsy certificate 2 X No 1 Yes 1 ☐ Yes Division of Vital Hospital or Attending Physician: 25. Was case referred to medical director 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 💢 No 2 ER/Outpatient 3□ DOA this funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation hours after death unerel Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in 24 hours the Funerel Directory filled in by þ 4 Homicide 1 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier within 24 ho
To the Fund
completely f 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and tille of certifier mornism WW. D53367 December 23, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10801 Darnestown Road, #202, Gaithersburg, MD Shyamsundar Rajan, M.D.

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year DEC 2

ORIGINAL

Geren & Spark

32. Reastrar's Signature

|                |   |                  | 1 - For State Registrar  | State of Ma   |                               | epartment<br>Pertificate                               |                      |                        | nd M      |                                       | giene<br>Reg(No) 0 5                    | 41822   |  |
|----------------|---|------------------|--|---|-------------------------------|--|----------------------|------------------------|-----------|---------------------------------------|---|---|--|
| 3              | Physic  | ian              | Decedent's Name (First, Middle, Last,  |   |                               |  |                      |                        |           | 2. Date of De<br>Month                |   | 3. Time of Death  |  |
| VE.            | /Medi   | cal              |  | .eBrun  |                               |  |                      |                        |           | CEMBE                                 | R 23,20                                 | 05 8:28 P M   |  |
|                | Examir  | ner              | 4a. Facility Name (If not institution, give<br>Saint Joseph M  | edical C  |                               | 4b. City, T  |                      | Tov                    | vs on     |                                       | Ba                                      | 4c. County of Death Baltimore                           |  |
|                | <ul><li>Funeral Director</li></ul>  |                  | 5. Social Security Number 6. Security Number 1 S | 7. Age  | 94 Yrs                        | Monthe   | Year<br>Days         | Hours                  | Min.      | 8. Date of Bin<br>(Month, Oa<br>March | 26 1911                                 | 9. Birthplace (State or Foreign<br>Country)<br>Maryland |  |
|                | land<br>w   |                  | 10a. State 10b. County   |   | 10c. City, Town o             | r Location   |                      |                        |           |                                       |   | 10d. Inside City Limits                                 |  |
|                | Mary<br>In sh   | to               | Md. Baltimo  | re  | Towson                        |  |                      |                        |           |                                       |   | 1 Tyes 2 No   |  |
|                | ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hyglene. If item 27 is marked other than "natural", or Itams 23a or 28a-f show or other traumatic avant, the Medical Exemirar must be nutified at | Funeral Director | 10e. Street and Number 702 Camberley Ci  | rcle C-8  |                               | 10f. Zip 0   | ode<br>204           |                        |           |                                       | 10g. Citizen of Wh                      | •   |  |
|                | death   | era              | 11. Marital Status   | 12. Was Decedent i  | Ever in U.S.                  |  |                      | panic Orig             | in? (Spe  | cify Yes or No                        | - 14 Race                               | USA<br>- American Indian,                               |  |
| 9              | after o   | Fun              | 1 Never Married 2 Marned   | Armed Forces? 1 ☐ Yes 2 ☐ N If Yes, Give X                        |                               | 13. Was Decede   |                      |                        | Puerto I  | Rican, etc.)                          | Black                                   | White, etc.   |  |
| 93             | iral', c  | d by             | 3 🔀 Widowed 4 □ Divorced   | Year or Dates:  |                               | 1 □ Yes 2  | (1 No                | Specify:               |           |                                       | Specify:                                | White   |  |
| 21215-0036     | "natu   | Completed        | 15. Decedent's Edu<br>(Specify only highest grade  | cation<br>e <i>completed)</i>                                     | 16a. De                       | ecedent's Usual<br>Give kind of work<br>fe. DO NOT use | Occupati<br>done du  | ion<br>ring most       | of workir | ng                                    | 16b. Kind of Bus                        | ness/Industry   |  |
| 12             | withir<br>ene.<br>then  | dmc              | Elementary/Secondary (0-12)  | College (1-4or 5  | +)                            | ecretary   |                      |                        |           |                                       | lung Ac                                 | sociation   |  |
| d 2            | filed withi<br>Hygiene.<br>other than<br>ant, the M   | Be Co            | 17. Father's Name (First, Middle, Last)  |   |                               | cer e car y  |                      | 8. Mother              | 's Name   | (First, Middle,                       | Maiden Sumame,                          |   |  |
| Maryland       | 2 should be filed withir<br>and Mental Hygiene.<br>Is marked other than<br>aumatic avent, the Me  | To B             |  | rbour   |                               |  |                      | Emm                    |           |                                       | yne                                     |   |  |
| Mar            | d 2 sh<br>th and<br>7 Is n<br>traun   |                  | 19a. Informant's Name/Relationship (Ty<br>Ms. Patricia Read/   |   |                               |  |                      |                        |           |                                       | er, City or Town, Si                    |   |  |
| o,             | 1 and<br>Health<br>tem 27<br>other tr   | 1 4              | 20a. Method of Disposition   | Daugircei   | 20b. Place of Di<br>cemetery, |  |                      |                        |           | ate                                   | m, Md. 2                                |   |  |
| υÖ             | ages<br>ent of<br>nt: If it   |                  | 1 ☐ Burial 2 ☐ Cremation 3 ☐ R<br>4 ☐ Donation 5 ☐ Other (Specify)   | lemoval from State  |                               | crematory or oth<br>Servic                             |                      |                        | 777       | /ns                                   | Towson                                  |   |  |
| Baltimore,     | permit. Pag<br>Department<br>Important: I<br>any injury o   |                  | 21. Signature of Funeral Savice Ucens  |   | 1111100                       | 22. Name and   | Address              | of Facility            |           |                                       |   | , Mu.   |  |
| ä              | Depa<br>Impo<br>any ir  |                  | ) KI   | 725   |                               | Ruck<br>1050   | Tow                  | ison l                 | Fune      | ral Hom                               | ne, Inc.<br>ld. 21204                   |   |  |
| 10 M           |   |                  | 23a. Part1. Enter the disease, or compli shock, or heart failure. List only or   | cations that caused<br>ne cause on each lin                       | the death. Do not             | enter the mode   | of dying,            | such as c              | ardiac oi | respiratory ar                        | rest,                                   | Approximate<br>Interval Between                         |  |
|                | Physician   |                  | Immediate Cause (Final disease or condition  | ACUTE C   | EREBROV                       | ASCULA   | R A                  | CCID                   | ENT       |                                       |   | Onset and Death 8 HOURS                                 |  |
| :3             | /Medical<br>Examiner  |                  | resulting in death)  | Due to (or as a   | a consequence of):            |  |                      |                        |           |                                       |   |   |  |
|                | *   | - L              | Sequentially list conditions,  |   | Consequence of):              | HINUPUL  |                      |                        |           |                                       |   | 8 HOURS   |  |
| #              | d<br>d<br>ansit   | Examiner         | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events  |   | ,                             |  |                      |                        |           |                                       |   |   |  |
| 0              | be executed<br>sician and<br>burial-transit   | Еха              | resulting in death) Last   |   | a consequence of):            |  |                      |                        |           |                                       |   |   |  |
| 8760,          | ate<br>hy:  | dlcal            | • •  | 1   |                               |  |                      |                        |           |                                       |   |   |  |
| 9 x            | eath certific<br>attending p<br>i for use as i  | /Mec             | IF FEMALE:   | 20 16 400 0 400 00  | 4                             |  |                      |                        |           |                                       |   |   |  |
| Вох            | eath c<br>attend<br>for us  | Physiclan/Med    | in the past 12 months?   | 3c. If yes, outcome of<br>1 ☐ Live birth<br>4 ☐ Pregnant at       | 2 Fetal death                 | 3 ☐ Ectopic preg                                       |                      |                        |           |                                       | 23d. Date of Month                      | •   |  |
| o.             | at the de<br>by the<br>tached   | ysic             | 1 ☐ Yes 2 🗖 No<br>9 ☐ Unknown  | 9□ Unknown  | unto or death                 | 3 🗆 Other (spec  | "Y)                  |                        |           |                                       |   |   |  |
| 0              | res that<br>igned b<br>be deta  | by Pt            | Part II. Other significant conditions con  | tributing to death bu   | t not resulting in th         | e underlying cau                                       | se given             | in Part I.             |           | 23e. Did to                           | bacco use contrib                       | ute to the cause of death?                              |  |
| Vital Records, | w require<br>been sig<br>should b   | ed t             |  |   |                               |  |                      |                        |           | 1 □ Y                                 | es 200 No 3                             | ☐ Probably 4 ☐Unknown                                   |  |
| BCO            | e law re<br>has be  | Completed        |  |   |                               |  |                      |                        |           | 24a. Was a                            |   | re autopsy findings available                           |  |
|                |   | Com              |  |   |                               |  |                      | -                      |           | autop<br>perfor<br>1  Yes             | med? dea                                | or to completion of cause of ath?  Yes 2 No             |  |
| /ita           | Physicien: 1<br>this certifical<br>al director, p   | Be               | 25. Was case referred to medical examiner?   | la na ika la  |                               |  | 1 .                  | 6. Place o             | of Death  | Check only or                         | ne                                      |   |  |
| of             | Phys<br>this<br>al dii  | .T               | 1 Yes 2 No   | ospital:<br>1  Inpatier<br>28a. Date of Injur                     |                               |  | Other:               |                        |           |                                       | ence 6 Other                            |   |  |
| on             | ding I<br>h.<br>After<br>funer  | ton              | 1 Natural 5 ☐ Pending  | (Month, Day   | y 28b. Tim<br>Year) Injur     | y M  | . Injury at<br>Work? | t<br>s 2 □ No          |           | Ba. Describe h                        | ow injury occurred                      |   |  |
| Division       | il or Attendi<br>after death.<br>Director: A<br>d in by the fu  | ifica            | 3 Suicide 6 Could not be   | 28e. Place of Inju  | ry - At home, farm,           |  |                      |                        |           | Bf. Location (S                       | treet and Number                        | or Rural Route Number,                                  |  |
| Ö              | s after   | Certification:   | 4 Homicide determined  | building, etc.  | . (Specify)                   |  |                      |                        |           | City or Tow                           | n, State)                               |   |  |
|                | To the Hospital or Attending within 24 hours after death. To tha Funerel Director: After completely filled in by the fune   | edical           | 29a. Certifier (Check only one) Certifying Phys  | sician: To the best of<br>ner: On the basis of<br>and manner stat | examination and/oi            | eath occurred at<br>r investigation, in                | the time,<br>my opin | date and<br>ion, death | place, ai | nd due to the o                       | ause(s) and mann<br>late and place, and | er as stated.<br>I due to the cause(s)                  |  |
|                | To the To the Complet   | Me               | 29b. Signature and title of certifier  |   | •                             | 29c. L   | icense n             | umber                  |           | 2                                     | 29d. Date signed (/                     | Month, Day, Year)                                       |  |
| )              |   |                  | April of al  | in (  | m, M.1                        | O. D   | 3921                 | 15                     |           |                                       | Decemen                                 | 23,200  |  |
|                | 5   |                  | 30. Name and address ct person who co  | mpleted cause of de   | ath (Item 23a) (Typ           |  |                      |                        |           |                                       |   | , -   |  |
|                |   |                  | GAIL CUNNINGHAM,   | M. D.,  | 7601 05                       | LER DR   | TUE                  | TOW                    | SON.      | MARY                                  | LAND 21                                 | 204   |  |
|                | Sta<br>Registr  | 200              | 31. Date filed (Month, Day Year) LEC 2 8 2   | 32. Peristra  | r's Signature                 | bosele   |                      |                        |           |                                       |   |   |  |

| ,00                        | O  |                   | 1 = For<br>State<br>Registrer   | State of Marylan   |   |  | of Health and of Death  |   | ene<br>2005                               | 41823  | 3           |
|----------------------------|--|-------------------|---|--|---|--|---|---|---|--|-------------|
|                            | Physici  |                   | 1. Decedent's Name (First, Middle, Last)  | $\sim$   | CD                                      | OWE  |   | 2. Date of Death<br>Month<br>DECEMBE        |   | 3. Time of Dear                                    | th M        |
|                            | /Medie<br>Examir   |                   | 4a. Facility Name (If not institution, give a 3614 W. GARRISON A  |  |   |  | wn, or Location of Deat   |   | 4c. County of Dea                         |  |             |
|                            | Funeral<br>Director  | a                 | 5. Social Security Number 6. Set 24 3-50 - 4356 1   | M 2□F 7. Age (In yrs.  | last birthday)<br>Yrs.                  | If Under 1<br>Months I                       | Year If Under 24 Hrs<br>Days Hours Min.                         | 8. Date of Birth<br>(Month, Day,            | (ear) 9. Bir<br>1937 Sn                   | thplace (State or For<br>ountry)<br>Uth (avic)     | reign<br>nA |
|                            | Maryland -f show   | tor               | 10a. State 10b. County  | 10c. Cit   | y, Town or Lo                           | cation                                       | (222210   | ,   |   | 10d. Inside City Lin                               |             |
|                            | 3e or 28a  | Il Director       | 10e. Street and Number  | arrein 1   | Ave.                                    | 10f. Zip C                                   | 21215   | 100   | g. Citizen of What Co                     | ountry?  |             |
| 21215-0036                 | d within 72 hours after death with the Maryland siene. Then "naturel", or items 23e or 28e-f show the Madical Examiner must be notified at   | by Funeral        | 11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced  | 12. Was Decedent Ever in U<br>Armed Forces?<br>1 Yes 2 No<br>If Yes, Give<br>Year or Dates:  | 1                                       | Vas Deceder<br>f Yes, specify                | t of Hispanic Origin? (S<br>Cuban, Mexican, Puer<br>No Specify: | Specify Yes or No-<br>to Rican, etc.)       | 14. Race - Ame<br>Black, Whit<br>Specify: |  |             |
|                            |  | Completed         | 15. Decedent's Edu<br>(Specify only highest grade<br>Elementary/Secondary (0-12)  |  | (Give                                   | dent's Usual (<br>kind of work<br>DO NOT use | done during most of wo<br>retired)                              | rking                                       | Se /f-e                                   | Industry mployed                                   | P           |
| Maryland 2                 | ges 1 and 2 should be filed<br>it of Health and Mental Hygi<br>if Item 27 ie marked other<br>or other traumalic event, I   | To Be C           | 17. Father's Name (First, Middle, Last)   | IC Dowe L  | _                                       |  | 18. Mother's Nar  | me (First, Middle, Ma                       | den Sumame)                               | n  |             |
| -                          | alth and A<br>27 ie ma<br>r trauma   |                   | 19a. Informant's Name/Relationship (Ty, Malindu Barr  | pe, Print)   | 19b. Mailin                             | g Address (S                                 | itreet and Number or Ri   |   |   | Zip Code)<br>2 i 20 7                              |             |
| Baltimore                  | nit. Pages 1 artment of He ortant: if iten injury or oth   |                   | 20a. Method of Disposition  1 ☐ Burial 2 Cremation 3 ☐ R  4 ☐ Donation 5 ☐ Other (Specify)  |  | lace of Disponentery, cren              | natory or other                              | r place)  | Date 20<br>2-8/05 (                         | oc. Location · City or                    |  | f.          |
| Balt                       | permit. Page<br>Department of<br>importent: if<br>eny injury or<br>once.   |                   | 21. Signature Funeral Service Liceose   |  | 1 6                                     | . Name and                                   | Addres Facility To Fred H Pinarch                               | Timera                                      | 955                                       | neto, md?  | 1229        |
| W                          | Physician /Medical business and physician and physician and the pricial-transit the pricial-transit physician for the physician physicia | Examiner          | 23a. Part1. Enjer the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | Due to (or as a consequent   | uence of):                              | iva c  | L. July   | c or respiratory arres                      |   | Approximate<br>Interval Between<br>Onset and Death | 1           |
|                            | The law requires that the death certificate best hes been signed by the ettending physic bage 2 should be detached for use as the b  | Physician/Medical | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown   | 3c. If yes, outcome of pregna 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of do   | death 3                                 | Ectopic preg<br>Other (speci                 |   | •   | 23d. Date of del<br>Month                 | ivery<br>Day Year                                  |             |
| rds, P.                    | w requires that<br>been signed b<br>should be deta   | ed by P           | Part II. Other significant conditions con   | tributing to death but not resi  | ulting in the ur                        | derlying caus                                | se given in Part I.   |   | cco use contribute to                     | the cause of death?                                |             |
|                            | stolen: The law re<br>certificate hes be<br>irector, page 2 sho  | Completed by      |   |  |   |  |   | 24a. Was an autopsy performe                | 24b. Were au prior to death?              | utopsy findings availa<br>completion of cause      | ible<br>of  |
| Division of Vital Records, | ding Phy<br>J.<br>After this<br>funeral d  | tion; To Be       | 27. Manner of Death   | ospital: 1  Inpatient 2  Inpati | ER/Outpatient<br>28b. Time of<br>Injury | 28c.   | Other: 4 Nursing H<br>Injury at<br>Work?                        | ome 5 Residence 28d. Describe how           |   | city) SCENE  |             |
| Divisi                     | To the Hospitel or Attenwithin 24 hours after death To the Funeral Director: completely filled in by the   | Certification;    | 2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined   | 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Str   |   |  |   | 28f. Location (Stree<br>City or Town, S     | et and Number or Ru<br>State)             | ıral Route Number,                                 |             |
|                            | he Hospit<br>in 24 hour<br>he Funera<br>pletely fille  | Medical (         | 29a. Certifier (Check only one) 1 ☐ Certifying Phys 2 ☐ Medical Exemin  | ician: To the best of my kno-<br>ner: On the basis of examinat<br>and manner stated.   | wledge, death<br>ion and/or inv         | occurred at testigation, in                  | he time, date and place<br>my opinion, death occu               | , and due to the causered at the time, date | se(s) and manner as<br>and place, and due | stated.<br>to the cause(s)                         |             |
| <b>)</b>                   | To T<br>To t   | Σ                 | 29b. Signature and title of certifier  heading  | 1. Viny mus  | -                                       | 29c. L                                       | ocmse number  |   | Date signed (Monti                        |  |             |
|                            | 3  |                   | 30. Name and address of person who con THECOOKE M. KING   |  | 111                                     |  | TREET, BAL  | ΓΙΜΟRE. ΜΑ                                  | RYLAND 2                                  | 1201   |             |
|                            | Sta<br>Registr   |                   | 31. Date filed (Month, Day, Year)  DEC. 2. 8. 2005  | 32. Registrar's Signa  | ture Space                              | w  | , –   | ,   |   |  |             |

|                            |  |                  | 1 - For State Registrar   | State of Maryland  | Department of Health and Certificate of Death  | Mental Hygiene  | 41824  |
|----------------------------|--|------------------|---|--|--|---|--|
|                            | Physic   |                  | 1. Decedent's Name (First, Middle, Last   |  | 1c Clain   | 2. Date of Death Month Day DECEMBER 22, 20                                      | 3. Time of Death 005 5:55 PM                       |
|                            | /Medi<br>Exami   |                  | 4a. Facility Name (If not institution, give RT 170 @ RT 100   |  | 4b. City, Town, or Location of Deal SEVERN   | th 4c. County of Dea  | ath  |
|                            | Funeral  | Г                | Social Security Number 6. Sec.  | 7. Age (In yrs. last   | birthday) If Under 1 Year If Under 24 Hrs  | ANNE ARU  S. 8. Date of Birth (Month, Day, Year)  (Month, Day, Year)            |  |
|                            | Director   | (                | Usual Residence of Decedent  10a. State 10b. County   |  | Yrs.   | may 31, 1982 Was  | inplace (State or Foreign Country)                 |
|                            | Maryla<br>R-f eho  | tor              | and Anne Ar   | rendel   | own or Location Severe   |   | 10d. Inside City Limits 1 ☐ Yes 2 XNo              |
|                            | with the   | Direc            | 10e. Street and Number  | Drive  | 10f. Zip Code 2 1 1 41 j   | 10g. Citizen of What C  | ountry?  |
| 9                          | be filed within 72 hours after deeth with the Maryland tal Hygiene. Id other than "natural", or Items 23a or 28a-f show event, I're Medical Exertiest must be notified at  | Funeral Director | 11. Marital Status  12 Never Married 2 Married  | 12. Was Decedent Ever in U.S.<br>Armed Forces?<br>1 ☐ Yes 2 ☑ No | 13. Was Decedent of Hispanic Origin? (S<br>If Yes, specify Cuban, Mexican, Puer                  | to Rican, etc.) Black, Whi  | ite, etc.  |
| 5-0036                     | 2 hours<br>atural',  | ted by           | 3 Widowed 4 Divorced  15. Decedent's Edu  | If Yes, Give Year or Dates:                                      | 1 ☐ Yes 2 ☐ No Specify:  6a. Decedent's Usual Occupation   | Specify:  | 3/acc  |
| 2121                       | filed within 7:<br>Hygiene.<br>Ither than "n   | Completed        | (Specify only highest grade Elementary/Secondary (0-12)   | College (1-4or 5+)   | (Give kind of work done during most of wo<br>life. DO NOT use retired)                           | rking   | ale  |
| Maryland                   | should be fill he marked oth   | To Be            | 17. Father's Name (First, Middle, Last)   | McClain  |  | me (First, Middle, Maiden Sumame)   |  |
| Mary                       | 12 sh<br>h and<br>h and<br>7 is m<br>treum   |                  | 19a. Informant's Name/Relationship (Ty  |  | 9b. Mailing Address (Street and Number or Ru   |   |  |
| ore,                       | of Heel  |                  | 20a. Method of Disposition  1 Surial 2 Cremation 3 R  | 20b. Place   | of Disposition (Name of Itery, crematory or other place)   | Date 20c. Location - City or  |  |
| Baltimore,                 | rtmen<br>rtmen<br>rtant:<br>njury  |                  | 4 Donation 5 Other (Specify)  21. Signature uneral \$ervior Liceris   | 2  | Cest Con. 12/2 22. Name and Address of Facility  | \$105 Seven   | , md.  |
| ä                          | Depermine the permitted the pe |                  | Jany John   | el   | 22. Name and Address of Facility  Camp march Fu o not enter the mode of dying, such as cardiac   | nord one on   | clo. nd . 21229                                    |
|                            | Physician  |                  | shock of heart failure. List only or Immediate Cause (Final disease or condition                            | re cause on each line.   | o not enter the mode of dying, such as cardiac   | ; or respiratory arrest,  | Approximate<br>Interval Between<br>Onset and Death |
|                            | /Medical<br>Examiner   |                  | resulting in death)   | Due to (or as a consequence                                      | se of):  |   |  |
| 16                         | nsit   | Examiner         | Sequentially list conditions, if any, leading to introduce cause. Enter Underlying Cause (Disease or injury | Due to (or as a consequence                                      | e of).   |   |  |
| 50,                        | ificate be executed<br>g physicien and<br>as the burial-transit  |                  | that initiated events cresulting in death) Last   | Due to (or as a consequence                                      | er of):  |   |  |
| 68760                      | rtificate b<br>ng physia<br>as the b   | fedical          | JE SELLIS   |  |  |   |  |
| P.O. Box                   | w requires that the death certi<br>been signed by the attending<br>should be detached for use a  | Physician/M      | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown                     | 23d. Date of del<br>Month  | livery<br>Day Year   |   |  |
|                            | law requires that the<br>es been signed by th<br>2 should be detache   | by               | Part II. Other significant conditions con   | tributing to death but not resulting                             | in the underlying cause given in Part I.   | 23e. Did tobacco use contribute to  | o the cause of death?                              |
| Division of Vital Records, | 2 8 8  | Completed        |   |  |  | 24a. Was an 24b. Were au prior to performed? d.au??                             | utopsy findings available completion of cause of   |
| Vita                       | rsician:<br>s certific<br>director,  | To Be (          | 25. Was case referred to medical examiner?  1 X Yes 2 □ No  | ospital:<br>1 ☐ Inpatient 2 ☐ ER/C                               |  | th (Check only one)   |  |
| o uc                       | Attending Physician: In death. Sector: After this certifice by the funeral director, is  | Ilon: T          | 27. Manner of Death 1 □Natural 5 □ Pending  | Tax Tax Tax Tax Tax Tax Tax Tax Tax Tax                          | Time of 28c. Injury at linjury Work?   | ome 5 Residence (XXOther (Special Describe how injury occurred dy               | iver in  |
| Divisi                     | To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page   | Certification:   | 2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined                                     | 28e. Place of Injury - At home, 1 building, etc. (Specify)       | 1 ☐ Yes 2 X No  farm, street, factory, office  | 281. Location (Street and Number or Ru<br>City or Town, State) Pt. 170 at       | real Poute Number                                  |
|                            | To the Hospital or within 24 hours afte To the Funeral Dir completely filled in I  | Medical C        | 29a. Certifier 1 Certifying Phys. (Check only one)  | er: On the basis of examination a                                | ge, death occurred at the time, date and place, and/or investigation, in my opinion, death occur | and due to the cause(s) and manner as rred at the time, date and place, and due | stated.  |
|                            | To the within To the Comple  | Me               | 29b. Signature and title of certifier  Pamed Sniffner   | and marrier stated.  | 29c. License number<br>O C M E   | 29d. Date signed (Monti<br>DECEMBER 2   | h, Day, Year)                                      |
|                            | 2  |                  | 30. Name and address of person who cor  | npleted cause of death (Item 23a)                                | ) (Type, Print)<br>111 PENN STREET, B  | BALTIMORE, MARYLAND   | 21 201   |
|                            | Sta  | ~~               | Pamela E Saithe<br>31. Date filed (Month, Day, Year)<br>DEC 2 8 2005  | 32. Registrar's Signature  | ,  | ALITHORE, MAKILAND  | , 21201  |
| 3                          | Registr  | al               | 000 6 6 2003  | Marie No 19  |  |   |  |

Mildred McClain Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. ter#23a,27,28a-f, per/IE,0851,1/26/06 TI State of Maryland / Department of Health and Mental Hygiene \(\hat{1}\) \(\sigma\) 05-08679 Unpend item# RJ 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) Date of Death
 Month Year **Physician** area 9:40 a. December 23, 2005 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner University of Maryland Hospital Baltimore If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 M 2 XE 2 219-72-6715 Director Maryland -04-1962 Usual Residence of Decedent the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28e-f show notified at 1 Ses 2 No NIA by Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? filed within 72 hours after death with the Modical Examiner must be Blossom Way 2 U 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? or iteme 11. Marital Status 1 Never Married 2 Married 1 Yes 2 No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates: Specify Black 3 Widowed 4 Divorced naturai Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 1spatcher 10 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sulmame) . Pages 1 and 2 should be filt timent of Heelth and Mental Hitant: If Item 27 is marked oth fury or other traumatic even Be 19a. Informant's Name/Relationship (Type, Print) MOTIEV Route Number, City or To 19b. Mailing Address (Street and Number or Rural 1 Walbre 15/4di 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Department of important: If any injury or armo undalk, Nid permit. 22. Name and Address of Facility Home P.A 21. Signature of Funeral Service Licenses Funeral 2222 W. North Ave, Baltimore Approximate Interval Between Onset and Death 23a. Part. Enter the disease, or com shock, or heart failure. List only mplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, by one cause on each line. Immediate Cause (Final Physician a. Fentanyl Intoxication resutting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, fary, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Records, P.O. Box 68760. Completed by Physician/Medical as the IF FEMALE esn n 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? ŏ Day signed by the at the deteched for 4☐Pregnant at time of death 5 Other (specify) 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably plnods 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an page 2 autopsy performed? 2 ☐ No Division of Vital within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1X Yes 2 □ No Medical Certification: To 1 Inpatient 2 XER/Outpatient 3 DOA 28a. Date of Injury 111 | 28b. Time of FM | 12/23/05 | 8:40 A M unk 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 🖔 No 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 708 Cherry Blossom Way 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide Baltimore, MD 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier OCME December 23, 2005 20 lampre cause of death (Item 23a) (Type, Print) 111 Penn Street Baltimore, Maryland 21201

State Registrar 31. Date filed (Month, Day, Year)
DEC 2 8 2

8 2005

KORE

32. Registrar's Signature

1 - For State Registrar

10a. State

MD

11. Marital Status

5. Social Security Number

10e. Street and Number

213-28-5276

1 Never Married 2 Marned

3 ₩ Widowed 4 Divorced

Usual Residence of Decedent

Physician

/Medical

Examiner

**Funeral** 

Director

rai', or items 23s or 28s-f show Exeminer must be notified at

Director

Funerai

δ

with the Maryland

urs after death

1. Decedent's Name (First, Middle, Last)

MARIE C. MCCALL

10b. County

4a. Facility Name (If not institution, give street and number)

Sinai Hospital of Baltimore

N/A

4017 DORCHESTER ROAD

1 M 2 T

| 21215-0                                   | filed within 72 ha<br>Hygiene.<br>Ither than "natu<br>int, the Medical  | Completed         | 15. Decedent's<br>(Specify only highest g   | rade completed)  | (                         | Decedent's Usual Occu<br>'Give kind of work done<br>life. DO NOT use retire | during most of w            | orking                                  | 16b                   |
|---|---|-------------------|---|--|---------------------------|---|-----------------------------|---|-----------------------|
| 212                                       | 2 should be filed within and Mental Hygiene. Is marked other than aumatic event, the Me   | Som               | Elementary/Secondary (0-12) 12TH  | College (1-4or 5+) 2 YEARS   |                           | NURSE   | -,                          |   |                       |
| 멀   | be file<br>ital Hy<br>id oth  | Be (              | 17. Father's Name (First, Middle, Las   | st)  |                           |   | 18. Mother's N              | ame (First, Midd                        | de, Maio              |
| <u>a</u>                                  | should b<br>nd Ment<br>marked<br>umatic   | To                | WISDOM CANNO  | N  |                           |   | ELISH                       | IA HINE                                 | ES                    |
| ar  | 2 sho<br>and<br>le mu   |                   | 19a. Informant's Name/Relationship  | . ,, .   |                           | Mailing Address (Street   |                             |   |                       |
| ≥ ≥                                       | 1 and 2<br>Health<br>lem 27 I   |                   | WENDY M. BROW   | N/GRANDDAU   | GHTER                     | 4317 DAV  | IS AVE,                     | BALTI                                   | MOR                   |
| nore                                      | Pages 1<br>nent of He<br>int: If Iter   |                   | 20a. Method of Disposition  X XXBurial 2 ☐ Cremation 3  4 ☐ Donation 5 ☐ Other (Special Control of the Control | Removal from State   | cemetery                  | Disposition (Name of crematory or other plants P. P.                        | ∞)<br>ARK 12/               | Date 30 / 05                            | 20c.                  |
| Baltimore, Maryland                       | permit. Pages 1 and 2 should be filed within 72 h<br>Department of Health and Mental Hygiene.<br>Important: If Item 27 is marked other than "natu<br>any injury or other traumatic event, the Medical<br>ODGE.                                      |                   | 21. Signature of Funeral Service Lic  | **   | 20                        | 22. Name and Addre  | ess of Facility             | OWELL                                   | FUN                   |
| -   |   |                   | 23a. Part Enter the dispase, or co  | mplications that caused the<br>ty one cause on each line.              | death. Do no              | 4600 L  | IBERTY<br>ng, such as cardi | HEIGHT<br>ac or respiratory             | 'S A                  |
|   | Physician<br>/Medical   |                   | Immediale Cause (Final disease for condition resulting in death)  | a Aspir  | ation                     | Preumo  |                             |   |                       |
|   | Examiner  |                   | •   | Due to (or as a co   |                           | 1   | inde t                      |   |                       |
|   | 要   | ē                 | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying  | b. Due to (or as a co  | onsequence of             |   | 1 den                       |   |                       |
| W   | uted  | Examiner          | cause. Enter Underlying Cause (Disease or injury that initiated events  |  |                           |   |                             |   |                       |
| Ò   | exec<br>an an<br>rial-tr  |                   | resulting in death) Last  | Due to (or as a co   | onsequence of             | ):  |                             |   |                       |
| 94  | ysicii  | cai               |   | d  |                           |   |                             |   |                       |
| 89  | ntifica<br>ng ph<br>as th   | Med               | IF FEMALE:  |  |                           |   |                             |   |                       |
| Š   | es that the death certificate be executed igned by the attending physician and be detached for use as the burial-transit  | Physician/Medical | 23b. Was decedent pregnant in the past 12 months?   | 23c. If yes, outcome of p  | regnancy<br>Fetal death   | 3 Ectopic pregnanc  | у                           |   |                       |
| o.  | the a   | /sic              | 1 ☐ Yes 2 ☑ No<br>9 ☐ Unknown   | 4□Pregnant at tim<br>9□Unknown   | e of death                | 5 Other (specify)   |                             |   | -                     |
| م   | that the  | Phy               | Part II. Other significant conditions   | contributing to death but n  | ot resulting in           | the underlying cause or   | ven in Part I               | 23e Di                                  | d tobacc              |
| ds,                                       | uires<br>signi<br>id be   | d by              |   | ,  | <b>g</b>                  | g,  |                             |   | ⊒ Yes                 |
| Ö   | v requ  | ete               |   |  |                           |   |                             |   |                       |
| Division of Vital Records, P.O. Box 68760 | Attending Physicien: The law requires that the death certificate be executed rdeath.  sctor: After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transit | Completed         |   |  |                           |   |                             | 24a. Whau pe                            | topsy<br>rformed      |
| Vita                                      | icien:<br>ertific   | Be                | 25. Was case referred to medical examiner?  | the minds  |                           |   |                             | eath (Check onl                         | у оле)                |
| of  | Physical this call dir  | 2                 | 1 Yes 2 No  | Hospital:  | 2 ER/Outp                 | ALIGIN OL BOX   |                             | Home 5 □ Re                             |                       |
| ion                                       | anding l<br>ath.<br>or: After<br>ne funer   | ation             | 27. Manner of Death  1 √Natural 5 ☐ Pending 2 ☐ Accident investigati  |  | ear) 28b. Tie             | ury Wo  | ryat<br>rk?<br>]Yes 2 ☐ No  | 28d. Describ                            | e how in              |
| Divis                                     | al or Atterde<br>after de<br>Directo  | Certification:    | 3 ☐ Suicide 6 ☐ Could not<br>4 ☐ Homicide determine   |  | At home, farr<br>Specify) | n, street, factory, office  |                             | 28f. Location<br>City or 7              | (Street<br>Town, St   |
|   | <ul> <li>Hospital or Attending Physicien: The law requir 24 hours after death.</li> <li>Funeral Director: After this certificate has been s letely filled in by the funeral director, page 2 should</li> </ul>                                      | dicai C           | 29a. Certifier (Check only one)   | Physician: To the best of maminer: On the basis of exand manner stated | amination and             | death occurred at the ti<br>for investigation, in my o                      | me, date and place          | ce, and due to the<br>curred at the tim | ne cause<br>e, date a |
|   | To the vithin 2 To the complet  | Me                | 29b. Signature and title of certifier   | and marmer stated  |                           | 29c. Licen:   | se number                   |   | 29d. I                |
|   | 0 4 4 4   |                   | ▶ Kazi A.o  | Eaman, N   | 1.D.                      | R   | ES-00                       | 0                                       | D.                    |
|   | X   |                   | 30. Name and address of person who KAZI A. ZAN  |  | (Item 23a) (T<br>SIA      | ype, Print)<br>IAI HOSPI  | TAL                         | OF BI                                   | ALT.                  |
|   | Sta<br>Registr  |                   | 31. Date filed (Month, Day, Year)   | 32. Redistrar's  |                           | boods   |                             |   |                       |
| 102                                       | n (-4.7) F-1  |                   | 111 11 11   | 1 / LIUU   |                           | 1 - 1   |                             |   |                       |

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Dav Year 11:05 AM 2005 December 22 4b. City, Town, or Location of Death 4c. County of Death Baltimore City If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth 0 7 / 0 8 / 1 9 1 7 9. Birthplace (State or Foreign Country)
S. CAROLINA 10d. Inside City Limits BALTIMORE CITY Yes 2 No 10g. Citizen of What Country? 21207 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 XNo Specify: Specify: BLACK Kind of Business/Industry MEDICAL fen Sumame) ty or Town, State, Zip Code) E, MD 21229 Location - City or Town, State AUREL, MD ERAL HOME 21207 VE, BALTIMORE, MD 5 days 1 month 23d. Date of delivery Day Year co use contribute to the cause of death? 2 No 3 Probably 4 Donknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 6 ☐Other (Specify) lury occurred and Number or Rural Route Number, e(s) and manner as stated. and place, and due to the cause(s) Date signed (Month, Dey, Year) ecember 22, 2005 IMORE

Registrar

8 2005

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

10f. Zip Code

7. Age (In yrs. last birthday)

Yrs.

10c. City, Town or Location

88

12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates:

|  |                      |  | State of Marylan  | nd / Departn                                | nent of Health and   | Mental Hygier  | ne  |                                       |
|--|----------------------|--|---|---|--|--|---|---------------------------------------|
|  |                      | 1 - For State Registrar  | Oldio of Marylar  |   | cate of Death  | Reg. 1   | Z 1 1 1 1 5                               | 41827                                 |
|  |                      | Decedent's Name (First, Middle, Las  | (t)   |   |  | 2. Date of Death                                     |   | 3. Time of Death                      |
| Physic<br>/Medi  |                      | Aboraham   | Martin  |   |  |  | Day Year                                  | 645pm                                 |
| Exami  |                      | 4a. Facility Name (If not institution, give  | street and number)  | 4b.   | City, Town, or Location of De  |  | 4c. County of Death                       |                                       |
|  |                      | GENESIS SIDER  | CARE Liberty  |   | condell stow   | O F  | Bullim                                    | e comme                               |
| Funeral  |                      | 5. Social Security Number 6. Se  | med a s o o o o   |   | Under 1 Year If Under 24 Hoths Days Hours M  | n. (Month, Day, Ye                                   | ar) 9. Birth                              | place (State or Foreig<br>ntry)<br>SC |
| Director   |                      | Usual Residence of Decedent  | 98  | 115.  |  | 09.07.19   | []  | _30                                   |
| Mo III   |                      | 10a. State 10b. County   | 10c. Ci   | ty, Town or Locatio                         | 1  |  |   | 10d. Inside City Limit                |
| 5 3  | to                   | MD NA  | BAI   | JIMORE                                      |  |  |   | 1 Mayes 2 □ Ne                        |
| Deportment of Health and Mental Hygiene.  Importent: If item 27 is marked other then "natural", or items 23e or 28e-f show any injury or other treumatic event, the Medical Examinar must be notified at once.   | Funerai Director     | 10e. Street and Number   |   | 10  | f. Zip Code  | 10g.   | Citizen of What Cou                       | ntry?                                 |
| 23e  | rai                  | 407 LOUDON STR   | EET   |   | 21229  |  | USA                                       |                                       |
| tems   | nue                  | 11. Marital Status   | 12. Was Decedent Ever in U<br>Armed Forces?                                       | I.S. 13. Was If Yes                         | Decedent of Hispanic Origin?<br>, specify Cuban, Mexican, Pu                             | (Specify Yes or No-<br>erto Rican, etc.)             | 14. Race - Ameri<br>Black, White          |                                       |
| o -  | by Fi                | 1 Never Married 2 Married 3 Widowed 4 Divorced   | 1 ☐ Yes 2 💆 No<br>If Yes, Give<br>Year or Dates:                                  | 101   | es 20XNo Specify:  |  | Specify: R)                               | ACK                                   |
| itural<br>E E  | edt                  | 15. Decedent's Ed  |   | 16a. Decedent's                             | Usual Occupation   |  | . Kind of Business/Ir                     |                                       |
| n "n   | plet                 | (Specify only highest grade Elementary/Secondary (0-12)                                      | de completed)  College (1-4or 5+)   | (Give kind<br>life. DO N                    | of work dane during most of v<br>OT use retired)   |  |   |                                       |
| giene<br>or the  | Completed            | 11 TH GRADE  | NA  | STATE E                                     | EMPLOVEE_  | 8  | TATE OF                                   | MD                                    |
| othe<br>vent,  | Be                   | 17. Father's Name (First, Middle, Last)  | ,   |   |  | ame (First, Middle, Maid                             | len Sumame)                               |                                       |
| Menta<br>arked<br>atic e   | D O                  | WILLIE MARTIN  |   |   | ADA HI   | LTON   |   |                                       |
| is m   |                      | 19a. Informant's Name/Relationship (7  | 150000  | 19b. Mailing Ad                             | dress (Street and Number or  |  |   | p Code)                               |
| tealth<br>m 27<br>her t  |                      | DENIA HIGHOWE  |   | Place of Disposition                        |  | 2. NW , WAS  | Location - City or T                      | 20000                                 |
| if of h  |                      | 20a. Method of Disposition  1 🗷 Burial 2 🗆 Cremation 3 🗆                                     | Removal from State  | cemetery, cremator                          | y or other place)  |  |   | own, otato                            |
| rtmer<br>rtent<br>njury  |                      | ' 4 □ Donation 5 □ Other (Specify  | - A   | - XION                                      |  |  | LTO. MD                                   |                                       |
| Dep<br>Imp<br>any  |                      | 21. Signature of Funeral Service Licen   | 366   | YAUG  | ne and Address of Facility   | FUNERAL SER  | VICE DIADO                                |                                       |
|  |                      | 23a. Part1. Enter the disease, or comp   | olications that caused the dear   |   | BAUO. NATU P   |  | 1VIO 21224                                | Approximate                           |
|  |                      | shock, or heart failure. List only of<br>transdiate Cause (Final                             | one cause on each line.   |   | 0 '  |  |   | Interval Between<br>Onset and Death   |
| iysician<br>Medical  | _                    | disease or condition resulting in death)   | aDue to (or as a consec   | TUBDOS OF                                   | dire   | 64 - 67  |   |                                       |
| aminer   |                      |  | Demens  |   | Dulales  | Lillen   | 9   |                                       |
|  | ē                    | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying           | b. Due to (or as a consec   | quence of).                                 |  | 1  |   |                                       |
| nd   | Examiner             | that initiated events  | C   |   |  |  |   |                                       |
| ysician and<br>ne burial-transit   |                      | resulting in death) Last   | Due to (or as a consec  | quence of):                                 |  |  | 1   |                                       |
| hysic<br>the bi  | licai                | •  | d   |   |  |  |   |                                       |
| ed by the attending phys<br>detached for use as the  | by Physician/Medi    | IF FEMALE:   | 23c. If yes, outcome of pregn.  | 0004  |  |  | 201 0-1-14-15                             |                                       |
| attend<br>for us   | ian                  | 23b. Was decedent pregnant in the past 12 months?  | 1 Live birth 2 Feta   | al death 3 Ecto                             | pic pregnancy<br>ar (specify)  |  | 23d. Date of deliv<br>Month               | Day Year                              |
| ched   | ysic                 | 1 Yes 2 No<br>9 Unknown  | 9 Unknown   | 70a(ii 3 0 0(ii                             | (specify)  |  |   |                                       |
| ed by<br>deta  | / Ph                 | Part II. Other significant conditions co   | ontributing to death but not res  | sulting in the underl                       | ring cause given in Part I.  | 23e. Did tobacc                                      | o use contribute to                       | the cause of death?                   |
| sign<br>Id be  | d b                  |  |   |   |  | 1 ☐ Yes  | 2 No 3 Pro                                | bably 4 🗆 Unknow                      |
| s been signed to<br>should be det  | Completed            |  |   |   |  | 24a. Was an  | 24b. Were aut                             | opsy findings availab                 |
| has<br>Je 2  | dmc                  |  |   |   |  | autopsy<br>performed                                 | ? death?                                  | ompletion of cause o<br>2 2 No        |
| certificate<br>rector, pag   | e)                   | 25. Was case referred to medical   |   |   | 26, Place of D   | 1  Yes 2 A   | 100                                       |                                       |
| s cer<br>direc   | To B                 | examiner?<br>1 Tes 2 No  | Hospital: 1 ☐ Inpatient 2 ☐   | ER/Outpatient 3                             | DOA Other: 4 Nursing   | Home 5 Residence                                     | 6 Other (Speci                            | fy)                                   |
|  |                      | 27. Manner of Death 1 Natural 5 ☐ Pending  | 28a. Date of Injury<br>(Month, Day Year)  | 28b. Time of<br>Injury                      | 28c. Injury at <-<br>Work?   | 28d. Describe how in                                 | njury occurred                            |                                       |
| ter thi  |                      | 1 Natural 5 Pending 2 Accident investigation   |   | ,   | 1 □ Yes 2 □ No   |  |   |                                       |
| aath.<br>or: After thi:<br>he funeral c  | atio                 | Z - Noordon  | 286. Place of injury - Acti   | ome, farm, street, f                        | actory, office   | 28f. Location (Street<br>City or Town, St            |   | al Route Number,                      |
| ier death.<br>irector: After thii<br>by the funeral c  | rtificatio           | 3 Suicide 6 Could not be determined  | building, etc. (Speci   |   |  |  |   |                                       |
| urs arrer dearn.<br>•rel Director: After this<br>fled in by the funeral c  | Certification:       | 3 Suicide 6 Could not be determined  |   |   | 24.0-24.0-0.00   | and the second second                                | for any                                   | aras a                                |
| 24 hours after death.<br>Funerel Director: After this<br>tely filled in by the funeral c   | lical Certificatio   | 3   Suicide 4   Homicide  3   Suicide determined   | ysician. To the best of my kni<br>niner: On the basis of examina                  | owledge, death occ<br>ation and/or investig | urred at the time, date and pla<br>lation, in my opinion, death of                       | ce, and due to the cause<br>curred at the time, date | e(s) and manner as and place, and due     | stated.<br>to the cause(s)            |
| thin 24 hours after death. 5 <b>the Funerel Director:</b> After thii mpletely filled in by the funeral c   | Medical Certificatio | 3 Suicide 4 Homicide  29a. Certifier (Check only one)  3 Suicide 6 Could not be determined   | ysician. To the best of my kin  | owledge, death occ<br>ation and/or investig | uned at the time, date and pic<br>lation, in my opinion, death of<br>29c. License number | curred at the time, date                             | and place, and due                        | to the cause(s)                       |
| within 24 hours after death.  To the Funerel Director: After this certifical completely filled in by the funeral director.   | Medical Certificatio | 3   Suicide 4   Homicide  3   Suicide determined   | ysician. To the best of my kni<br>niner: On the basis of examina                  | owledge, death occ<br>ation and/or investig | ation, in my opinion, death or   | curred at the time, date                             | and place, and due to Date signed (Month) | Day, Year)                            |
| within 24 hours after death.  To the Funerel Director: After this completely filled in by the funeral of   | Medical Certificatio | 3 Suicide 4 Homicide  29a. Certifier (Check only one)  29b. Signature and title of certifier | ysiciam. To the best of my kinder: On the basis of examination and manner stated. | ation and/or investig                       | 29c. License number  | curred at the time, date                             | and place, and due to Date signed (Month) | Day, Year)                            |
| within 44 hours aider deam.  To the Funerel Director: After this completely filled in by the funeral completely filled in the funeral comp | Medical Certificatio | 3 Suicide 4 Homicide  29a. Certifier (Check only one)  3 Suicide 6 Could not be determined   | ysiciam. To the best of my kinder: On the basis of examination and manner stated. | ation and/or investig                       | 29c. License number  | curred at the time, date                             | and place, and due                        | Day, Year)                            |

EM )5-08639 Amanda M. Moore

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

| la                         | TI. MOOI   | ٠. د            | 1 - For<br>Stete<br>Registrer   | State of Maryla                                   |                      | artment of hartificate of              |                                   | d Mental Hy                                | giene<br>Reg. No. | 05                             | 41828  |
|----------------------------|--|-----------------|---|---|----------------------|--|-----------------------------------|--|-------------------|--------------------------------|--|
|                            | Physici  | 20              | 1. Decedent's Name (First, Middle, Las  | t)  |                      |  |                                   | 2. Date of De<br>Month                     | eath<br>Day       | Year                           | 3. Time of Death                                   |
|                            | Physici<br>/Medic  |                 |   | Moore   |                      |  |                                   | Decembe                                    |                   | 2005                           | 2:27 P M   |
| j                          | Examin   | er              | 4a. Facility Name (If not institution, give   |   | t                    | 4b. City, Town, o                      |                                   | Death                                      |                   | unty of Death                  | and a to   |
|                            | Funeral  |                 | Southern Marylar  5. Social Security Number 6. Se   |   | s. last birthday)    | Clint                                  |                                   | Hrs. 8. Date of Bir                        |                   | nce Geo                        | place (State or Foreign                            |
|                            | Director   |                 | 217 04 0111   | □ M <b>X</b> X F 22                               | Yrs.                 | Months Days                            | Hours                             | Hrs. 8. Date of Bir (Month, Date Aug 8,    | 1983              | Cour                           | ginia  |
|                            | pue *  |                 | Usual Residence of Decedent  10a. State 10b. County   | 10c (   | City, Town or Lo     | cation                                 |                                   |  |                   | 1.                             | Od. Inside City Limits                             |
|                            | Maryli   | Į.              |   |   |                      |  |                                   |  |                   |                                | 1 ☐ Yes 2 ☐ No                                     |
|                            | r 28a-   | Director        | Maryland Prince  10e. Street and Number   | George S  | Berwyn_              | 10f. Zip Code                          |                                   |  | 10g. Citizen      | of What Cour                   | 71   |
|                            | th witi  |                 | 5607 Ruata  | n Street  |                      | 2074                                   | 2                                 |  | Unito             | d State                        | 05   |
|                            | r dea  | Funeral         | 11. Marital Status  | 12. Was Decedent Ever in<br>Armed Forces?         |                      | Was Decedent of I                      | lispanic Origin<br>an, Mexican, P | ? (Specify Yes or No<br>uerto Rican, etc.) | o- 14.            | Race - Americ<br>Black, White, | can Indian,  |
| 36                         | s afte   | by Fu           | XX Never Married 2 ☐ Married<br>3 ☐ Widowed 4 ☐ Divorced  | 1 ☐ Yes 2 XXVo<br>If Yes, Give                    |                      | 1□Yes 2√T√No                           | Specify:                          |  |                   |                                | hite   |
| 21215-0036                 | be filed within 72 hours after death with the Maryland ital Hygiene. d other then "naturel", or items 23s or 28s-f show event, its Madical Examinat motal be mailined at   | edb             | 15. Decedent's Ed   | Year or Dates:                                    | 16a, Dece            | dent's Usual Occur                     | pation                            |  | 16b. Kind o       | of Business/In                 |  |
| 215                        | hin 72   | Completed       | (Specify only highest gra   | de completed)  College (1-4or 5+)                 | (Give                | kind of work done<br>OO NOT use retire | during most of                    | working                                    |                   |                                |  |
| 2                          | ed wit   | Соп             | 12  | 4   | Stat                 | isician                                |                                   |  | Gover             | nment                          |  |
| and                        | be fill Hall Hall Hall Hall Hall Hall Hall H   | Be              | 17. Father's Name (First, Middle, Last)   |   |                      |  |                                   | Name (First, Middle                        |                   | name)                          |  |
| Maryland                   | d Mer<br>marke   | ဥ               | Gardiner M  19a. Informant's Name/Relationship (7)  | oore  | 10h Mailie           | Address /Ctroot                        | 1                                 | olyn Mo                                    | ran               | Ctata Ti-                      | . (0, 7-1)   |
| <u>≅</u>                   | nd 2 s<br>uith an<br>27 le<br>r trau   |                 | Carolyn Moore (   | •           |                      |  |                                   |  |                   |                                | 29588-6284   |
| Baltimore,                 | permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if Item 27 is marked other then "naturel", or Items 23a or 28a-f show wart futry or other traumatic event, the Medical Examiner mout be notified at ODGs. |                 | 20a. Method of Disposition  |   | . Place of Dispo     | sition (Name of<br>natory or other pla | ce) Lec                           | Date 30                                    | 20c. Locati       | on - City or To                | own, State   |
| Ĕ                          | Page<br>ment<br>ant: It<br>ury o   |                 | 1 ∰urial 2 □ Cremation 3 □<br>4 □ Donation 5 □ Other (Specify   |   | •                    | t Cemete                               | 1                                 | 2005                                       | Conwa             | y, Sou                         | th Carolina  |
| 3alt                       | Separt<br>Depart<br>Mport<br>Iny In  |                 | 21. Signatur vil Funeral Service Licen  |   |                      |  |                                   | ee Funera                                  |                   |                                |  |
|                            | 40204  |                 | 23a Part Enter the disease or come  | MO1461  |                      |  |                                   | y Rd, Cli                                  |                   | MD 207:                        |  |
|                            | Dhamisis   |                 | 23a. Park. Enter the disease, or comp<br>shock, or heart failure. List only<br>Immediate Cause (Final       | one cause on each line.                           | L. T.                | م ساه و                                | ng, such as car                   | rdiac or respiratory a                     | irresi,           |                                | Approximate<br>Interval Between<br>Onset and Death |
|                            | Physician<br>/Medical  |                 | disease or condition resulting in death)  | a. IV (u + ir                                     | equence of           | (16)                                   |                                   |  |                   |                                |  |
|                            | Examiner   |                 | Constantially that are distant  | b   | 0400.000             |  |                                   |  |                   |                                |  |
|                            | D #  | ner             | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | Due to (or as a conse                             | equence of):         |  |                                   |  |                   |                                |  |
|                            | and and I-trans  | Examiner        | that initiated events resulting in death) Last  | c. Due to (or as a cons                           | nguagae of):         |  |                                   |  |                   |                                |  |
| 8760,                      | ficate be executed<br>physicien and<br>s the burial-transit  | alE             |   | 200 10 (0. 20 2 001)                              | oquence on.          |  |                                   |  |                   |                                |  |
| 687                        | ificate<br>g phys<br>as the  | edical          | `   | d   |                      |  |                                   |  |                   |                                |  |
| Вох                        | th cert<br>endin   | M/us            | 230. Was decedent pregnant  | 23c. If yes, outcome of preg<br>1☐Live birth 2☐Fe |                      | Ectopic pregnanc                       | ,                                 |  | 23d.              | Date of delive                 | ery  |
| П                          | e deal   | sicie           | in the past 12 months? 1 ☐ Yes 2 ☐ No   | 4☐ Pregnant at time of                            |                      | Other (specify)                        | <b>,</b>                          |  |                   | Month                          | Day Year   |
| P.<br>O.                   | The law requires that the death certificate has been signed by the ettending is bege 2 should be detached for use as   | by Physician/Me | 9 Unknown Part II. Other significant conditions or  |   | ocultina in the      | adoch ing an una an                    | on in Dant I                      | 220 Did                                    | lahasas was s     |                                |  |
| ds,                        | signe<br>d be c  |                 | Tarrit. Other signmount conductis co  | Sittibuting to death but not in                   | esciting in the ur   | idenying cause giv                     | en in Part I.                     | 1 🗆  |                   |                                | ne cause of death?                                 |
| Division of Vital Records, | w requir<br>been si<br>should  | Completed       |   |   |                      |  |                                   | 24a. Was                                   |                   |                                | psy findings available                             |
| æ                          | The lav<br>te has<br>ege 2   | d mo            |   |   |                      |  |                                   | auto                                       | psy<br>ormed?     | prior to con<br>death?         | mpletion of cause of                               |
| Ħ                          |  | BeC             | 25. Was case referred to medical examiner?  |   |                      |  | 26. Place of                      | Death (Check only                          | 2□No<br>one)      | 1 Yes                          | 2 □ No   |
| <u>&gt;</u>                | Physic<br>this ce<br>al dire   | မ               | 1√2¥es 2 □ No   |   | <b>⊠</b> R/Outpatien | COLDON                                 |                                   | ng Home 5 ☐ Resi                           | dence 6 🗆         | Other (Specifi                 | y)   |
| Ä                          |  | ertification:   | 27. Manner of Death 1 □ Natural 5 □ Pending   | 28a. Date of Injury<br>(Month, Day Year)          |                      | Wo                                     |                                   | 28d. Describe                              |                   |                                | 11   |
| isi                        | deat<br>deat<br>ctor:<br>/ the   | licat           | 2 Accident investigation 3 ☐ Suicide 6 ☐ Could not be   | 10101103  | home farm str        | 1                                      | Yes 2 No                          |  |                   |                                | Collijion<br>I Route, Number,                      |
| á                          | al or a<br>s after<br>of in b  | Cert            | 4 Homicide determined   | building, etc. (Spe                               | st/eet               | -                                      |                                   | City or To                                 | wn, State) A      | lentaun                        | and  |
|                            | To the Hospital or Attending within 24 hours after death.  To the Funerel Director: After completely filled in by the funer  | edical (        | 29a. Certifier  (Check only 35-Medical Exam   | ysician: To the best of my k                      | nowledge, death      | occurred at the ti                     | me, date and p                    | lace, and due to the                       | cause(s) and      | manner as s                    | tated.   |
|                            | the H<br>hin 24<br>the F   | Medi            | GIIO)   | and manner stated.                                | mation and/or in     |  |                                   | occurred at the time,                      |                   |                                |  |
| <b>\</b>                   | 5 1× 100   | -               | 29b. Signature and title of certifier   | 11 -1-1   |                      | 29c. Licens                            |                                   |  |                   | gned (Month,                   |  |
|                            | ~  |                 | 30. Name and address of person who  | VVI C JT-   | em 23al (Tunn        | OCI                                    | TL.                               |  | Decem             | ber 22,                        | , 2003   |
|                            | 10   |                 | JACK M. Titus M   | D. 111 Pon  | n Stree              |  | ore Ma                            | ryland 21:                                 | 201               |                                |  |
|                            | Sta  |                 |   |   | nature               | B)                                     | -4 - 9 LICA                       | Lyauna 21                                  |                   |                                |  |
|                            | Registr  | -               | DEC 2 8 200   | a. Registrar's Sig                                | 17                   | -                                      |                                   |  |                   |                                |  |

|                |   |                  | 1 - For Sta  | te of Maryland /                                     |             |                               | Health and          | Mental Hyg                               | iene                                | 41829  |
|----------------|---|------------------|--|--|-------------|-------------------------------|---------------------|--|-------------------------------------|--|
|                |   |                  | Decedent's Name (First, Middle, Last)  |  |             |                               |                     | 2. Date of Oeat                          |                                     | 3. Time of Death                                 |
|                | Physic  |                  | Helen D. Mugra   | α e  |             |                               |                     | Month<br>Dec.                            | Day Year 27. 200                    |  |
|                | /Medi<br>Examir   |                  | 4a. Facility Name (If not institution, give street a                               |  |             | 4b. City, Town,               | or Location of De   |  | 4c. County of De                    |  |
|                |   |                  | 723 Umbra Street   | t  |             | Balt                          | imore               |  | n/a                                 |  |
|                | Funeral   |                  | 5. Social Security Number 6. Sex   | 7. Age (In yrs. last b                               | oirthday)_  | If Under 1 Yea<br>Months Days | r If Under 24 H     |  |                                     | irthplace (State or Foreign                      |
|                | Director  |                  | 218-10-4376 1□ M 2   | 84   | Yrs.        | Wortins Days                  | S Hours Wi          | 1/7/2                                    |                                     | aryland  |
|                | and *   |                  | Usual Residence of Decedent  10a. State 10b. County                                | 10c. City, To  | wn or Lac   | ation                         |                     |  |                                     | Table Inside City Limits                         |
|                | Aaryl<br>f sho  | ŏ                |  |  |             |                               |                     |  |                                     | 10d. Inside City Limits 1 XYes 2 No              |
|                | the t   | ect              | Md n/a  10e. Street and Number   | ва   | 1tin        | 10f. Zip Code                 |                     | 1  | 0g. Citizen of What C               |  |
|                | 3a or   | Ī                | 723 Umbra Street   |  |             |                               | 21224               | "  | •                                   | ountry?  |
|                | ms 2  | Funeral Director |  | s Decedent Ever in U.S.                              | 13. W       |                               |                     | (Specify Yes or No-                      | USA<br>14. Race - Am                | erican Indian                                    |
| 9              | or ita  | 표                | 1 Never Married 2 Married 1  | ned Forces?<br>]Yes 2⊠No                             |             | _                             |                     | (Specify Yes or No-<br>erto Rican, etc.) | Black, Wh                           |  |
| 8              | 72 hours after death with the Maryland<br>natural', or Itams 23a or 28e-f show<br>after Examiner outst by motified at | i by             | 3. ■ Widowed 4 □ Divorced Year   | es, Give<br>ar or Dates:                             | 11          | JYes 2 No                     | Specify:            |  | Specify:                            | White  |
| 21215-0036     |   | Completed        | 15. Decedent's Education (Specify only highest grade comp                          | leted)   | (Give ki    | nt's Usual Occu               | e during most of w  | opking                                   | 16b. Kind of Busines                |  |
| 12             | vithin<br>ne.<br>han  | mpi              | Elementary/Secondary (0-12) Col  | lege (1-4or 5+)                                      | life. Do    | O NOT use retir               | ed)                 |  |                                     |  |
| 2              | filed within Hygiene.   |                  | 17. Father's Name (First, Middle, Last)  | 0  | Но          | omemak                        |                     |  | Home                                |  |
| anc            | ould be f<br>Mental F<br>tarkad ot<br>tatic ever  | Be               |  | _  |             |                               | 18. Mother's N      | ame <i>(First, Middl</i> e, A            | faiden Sumame)                      |  |
| Maryland       | s 1 and 2 should be<br>Health and Menta<br>itam 27 is markad<br>other traumatic ev                                    | 10               | Julian Antonia  19a. Informant's Name/Relationship (Type, Pri                      |  | N- 14-11    | 4.44 (0)                      | M                   | ary Szar                                 | ek                                  |  |
| Ma             | d 2 sho<br>th and<br>t7 is mu   |                  | Boyd W. Mugrage, J   |  |             |                               |                     |  | City or Town, State,                |  |
|                | item 27   |                  | 20a. Method of Disposition   | 20b. Place of  | of Disposit | tion (Name of                 |                     |  | Md. 2122<br>20c. Location - City of |  |
| 0              | 0 0   |                  | 1 Burial 2 □ Cremation 3 □ Remova  | I from State cemete                                  | өгу, сгета  | tory or other pla             |                     |  | -                                   |  |
| altimore,      | 구두본글  |                  | * 4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service Licensee      | Oak  | Lawr        | Ceme 1                        | tery 12             | /30/05 L                                 | Baltimor                            | e, Md.   |
| Ba             | permi<br>Depar<br>Impo<br>any ir  |                  |  |  | 1 K a       | CZOTO                         | ₩SK1™Fu             | neral Ho                                 | ome P.A.                            | 41 01000   |
|                |   |                  | 23a. Part1. Enter the disease, or complications                                    | that caused the leath. Do                            | not enter   | the mode of dy                | ing, such as cardi  | ac or respiratory arre                   | imore, r                            | Approximate                                      |
|                | Physician   |                  | Immediate Cause (Final   | e on each line.                                      | 1.1-        |                               |                     | , , , , , ,                              |                                     | Interval Between<br>Onset and Death              |
|                | /Medical  |                  | disease or condition resulting in death)   | ue to (or as a consequence                           | 1700        | ER                            |                     |  |                                     |  |
|                | Examiner  |                  |  | and the same   | J 0.7.      |                               |                     |  |                                     |  |
|                | سيسي  | ner              | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying | ue to (or as a consequence                           | of):        |                               |                     |  |                                     |  |
| /              | cutec<br>nd<br>ransi  | Examine          | Cause (Disease or injury that initiated events                                     |  |             |                               |                     |  |                                     |  |
| Ő,             | ate be executed<br>hysician and<br>the burial-transit   |                  | resulting in death) Last   | ue to (or as a consequence                           | of):        |                               |                     |  |                                     |  |
| 8760,          | ate<br>hy:  | dicai            | d  |  |             |                               |                     |  |                                     |  |
| 9              | death certific<br>e attending pl<br>d for use as t  | ian/Med          | IF FEMALE:   |  |             |                               |                     |  |                                     |  |
| Вох            | ath co  | lan/             | in the past 12 months?   | es, outcome of pregnancy<br>Live birth 2 Petal death | h 3□E       | ctopic pregnanc               | су                  |  | 23d. Date of de<br>Month            | ,  |
| 0              | the de<br>ry the a  | Physici          | 1 □ Yes 2 No 4 □   | Pregnant at time of death<br>Unknown                 | 5 🗆 C       | other (specify) _             |                     |  | Month                               | Day Year   |
| Δ.             | that the di<br>led by the<br>detached   | Ph               | Part II. Other significant conditions contributin                                  | g to death but not resulting                         | in the und  | arlying cause of              | wen in Part I       | 23e Did tob                              | acco use contribute t               | o the cause of death?                            |
| Vital Records, | es<br>gu  | d by             |  | g  |             | onying oddso gi               | voir iii 7 ait i.   |  |                                     | robably 4 Durknown                               |
| Ö              | > 0 5   | Completed        |  |  |             |                               |                     | :  |                                     | , X  |
| Re             | e la<br>has<br>je 2   | mo               |  |  |             | · · · · · ·                   |                     | 24a. Was an autopsy perform              | prior to                            | utopsy findings available completion of cause of |
| a              | ician: Th   | CO               | 25 Was appointed to modical  |  |             |                               |                     | 1  Yes 2                                 | XNo 1 ☐ Yes                         | 2 No   |
| ₹              |   | o Be             | 25. Was case referred to medical examiner?  1 Yes 2 No Hospital:                   | 4 Edward at a Edward                                 |             | - C Ot                        | hor                 | eath (Check only one                     |                                     |  |
|                |   | -                |  | 1 Inpatient 2 ER/Out<br>Date of Injury 28b.          | Time of     | 3LI DOA                       | 4 U Nursing         | Home 5 Resider<br>28d. Describe how      | ice 6 Other (Spe                    | cify)  |
| on             | fe 4 - 4  | tior             | 1 Natural 5 Pending 2 Accident investigation                                       |  | Injury      | 28c. Inju<br>Wo               | rk?<br>]Yes 2□No    | 200. Describe not                        | v injury occurred                   |  |
| Division       | or Attending<br>after death.<br>Director: After<br>in by the fune   | ertification:    | 3 Suicide 6 Could not be 28e   | Place of Injury - At home, fa                        | arm, stree  |                               |                     | 28f. Location (Stre                      | eet and Number or R                 | ural Route Number.                               |
| -=             | al or A<br>s after<br>il Direction by   | Cert             | 4 Homicide determined  | building, etc. (Specify)                             |             | ,                             |                     | City or Town,                            | State)                              |  |
|                | Hospital of Hospital of Funeral Distely filled in   |                  | 29a. Certifier  Check colv  Check colv  Check colv  Check colv                     | To the best of my knowledge                          | e, death o  | ccurred at the ti             | ime, date and place | e, and due to the cau                    | use(s) and manner as                | s stated.  |
|                | To the Hospital or At within 24 hours after or To the Funeral Direct completely filled in by                          | edical           | Z medical Exeminer: On   | the basis of examination ar<br>manner stated.        | nd/or inves | stigation, in my              | opinion, death occ  | urred at the time, dat                   | te and place, and due               | to the cause(s)                                  |
|                | To the P<br>within 24<br>To the P<br>complete   | Σ                | 29b. Signature and title of certifier  |  |             | 29c. Licens                   |                     |  | d. Date signed (Mont                |  |
|                | /   |                  | Melle  |  |             | 172                           | 376.                | 7 1                                      | Decemb                              | er 27.200s                                       |
|                | h   |                  | 30. Name and address of person who completed                                       | cause of death (Item 23a)                            | (Type, Pri  | nt) (                         | - 0                 | 1 1 0                                    | 1. ~                                | Per 27,2005<br>1 21244                           |
|                |   |                  | DEBRAS WERTHEI   |  | 100         | 18 JEC                        | unityB              | INd, Ba                                  | 1to 16                              | 1 21244  |
|                | Sta<br>Registr  |                  | 31. Date filed (Month, Day, Year) DEC 2 8 2005                                     | 32. Registrar's Signature                            | sell!       | •                             | /                   |  |                                     |  |

| A C A TWO WAY OF THE DESCRIPTION AND THE WAY OF THE DESCRIPTION OF Location of Death A Facility Name (if not institution, give sized and number)  4.4. Eacility Name (if not institution, give sized and number)  5. Social Security Number  2. Social Security Number  2. Social Security Number  2. Social Security Number  3. Social Security Number   |              | 1 - For State Registrar  |  |   | Mental Hygie                       | ene<br>249.05 1.1830   |
|--|--------------|--|--|---|------------------------------------|--|
| 3. Social Sectionly Number   6. Sec   22.0 Be -8 0.08   M   3/2   7. App (firty as called the control of the co | dical        | Ada Threva<br>4a. Facility Name (If not institution, give  | Invay Matth  | 4b. City, Town, or Location of Dec          | Month 12                           | 4c. County of Death  |
| DE. SUSSEX BETHANY BEACH  10/6 Street and Number  f Park Report of Street Indian, etc.)  10/6 Street and Number of Street Indian, etc.)  10/6 Street Indian, etc.)  10/6 Street Indian, etc.)  10/6 |              | 5. Social Security Number 6. Se 220-18-8008  | 7. Age (In yrs. last birthda<br>M 2 1 F 80 Yrs.              | Months Days Hours Mi                        | 8. Date of Birth<br>(Month, Day, y | (ear) 9. Birthplace (State or Fore Country) TENN •                 |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, interval Betwee Approximate Interval Betwee Approximate Cause (finding in death)   1  | ector        | DE. SUSSEX   |  | Y BEACH                                     | 100                                | 10d. Inside City Lim 1 ☐ Yes 2 ☑                                   |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, interval Betwee Approximate Interval Betwee Approximate Cause (finding in death)   1  | eral Dir     | 758 HALF MOON I  |  | 19930                                       | 1                                  | USA  |
| 23. Part I. Enter the desase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition disease or condition disease or condition disease or condition disease or condition.  Sequentially list conditions.  I any, requiring to sentimental equations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.  Approximate Interval Betwee Onset and Death of Sequence of Sequence of Sequentially list conditions.  I any, requiring to sentimental equations and the conditions.  I any, requiring to sentimental equations and the conditions.  I any, requiring to sentimental equations and the conditions of the conditions and the conditions and the conditions of the conditions and the conditions and the conditions distinct the conditions and the conditions and the conditions are contributed to the cause of death distinct the conditions and the conditions and the conditions and the conditions and the conditions and the conditions and the conditions and the conditions are contributed to the cause of death of the conditions and the conditions are contributed to the cause of death of the conditions are contributed to the cause of death of the conditions are contributed to the cause of death of the conditions are contributed and the conditions are contributed and the conditions are contributed and the conditions are contributed and the conditions are contributed and the conditions are contributed and the conditions are contributed and the conditions are contributed and the conditions are conditions and conditions are conditions.  I prove a CNN or and the conditions are conditions and conditions are conditions and conditions are conditions.  I prove a condition are conditions are conditions and conditions are conditions.  I prove a condition are conditions are conditions and conditions are conditions.  I prove a condition are conditions.  I pro | by Fund      | 1 ☐ Never Married 2 🗷 Married  | 1 ☐ Yes 2 ☑ No<br>If Yes, Give                               |   | orto Rican, etc.)                  | Black, White, etc.   |
| 18. Mother's Name (First, Middle, Last)   18. Mother's Name (First, Middle, Masiden Surname)   | ompletec     | (Specify only highest grad   | ucation 16a. De (Gi   life 164                               |   |                                    |  |
| E. BRENT MATTHEWS (SON)  20a. Method of Disposition 1 Seural 2   Cramation 3   Removal from State 1 Operation   2   Command   2   2   2   2   2   2   2   2   2  | BeC          |  | DWAY   |   |                                    | iden Sumame)   |
| Sequential   Commation   Control (Specify)   DULANEY VALLEY   12/27/2005   TIMONIUM, MD.   |              | E. BRENT MATTHE  | EWS (SON) 4 C  | LAN CHATTAN LN                              | . TOWSON                           | ,MD. 21204.  |
| HENRY W. JERKINS & SONS CO.  16924 YORK RD MONKTON, MD. 21111.  18926 YORK RD MONKTON, |              | 1 Burial 2 □ Cremation 3 □ 1 Donation 5 □ Other (Specify   | Removal from State DULANEY                                   | VALLEY 12/2                                 | 7/2005 T                           | IMONIUM, MD.   |
| Sequentially list conditions. Lary, testuring to sminerize that Conditions. Lary, testuring to sminerize that Due to (or as a consequence of): | BDCB         | 1 relling Ch   | dies it  | 6924 YORK RD M                              | ONKTON, M                          | D. 21111.  |
| Testiting in death   Last   C.   Due to (or as a consequence of):  | al 🐇         | shock, or heart failure. List only of<br>Immediate Cause (Final<br>disease or condition<br>resulting in death)   | a. Myo Carch   | 1 1 1                                       |                                    | Approximate Interval Between Onset and Death                       |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause of death labeling to  | cal          | Sequentially list conditions, if any, leaturing to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | Due to (or as a consequence of).                             |   |                                    |  |
| 1   Yes   2   No   3   Probably   4-2/Unkn   24a. Was an autopsy performed?   1   Yes   2   No   1   Yes     | nysIclan/Med | 23b. Was decedent pregnant<br>in the past 12 months?<br>1 □ Yes 2 万No  | 1 Live birth 2 ☐ Fetal death : 4 ☐ Pregnant at time of death |   |                                    |  |
| 25. Was case referred to medical examiner?    1  | by           | Part II. Other significant conditions of   | ontributing to death but not resulting in the                | underlying cause given in Part I.           |                                    |  |
| examiner?  1   Yes   25   No  Hospital: 1/Sonpatient   2   ER/Outpatient   3   DOA   Cther: 4   Nursing Home   5   Residence   6   Other (Specify)  27. Manner of Death   28a. Date of Injury   28b. Time of Injury   Work?   Work?   1   Yes   2   No  28d. Describe how injury occurred  28d. Describe | O            |  |  |   | autopsy<br>performe                |  |
| 27. Manner of Death 1  | 0            | examiner?  | Hospital: 1/⊠inpatient 2 ☐ ER/Outpat                         | Other                                       |                                    | ee 6 □Other (Specify)  |
| 29a. Certifier (Check only one)  29b. Signature and title of pertifier  29c. License number  29a. Certifier (Check only one)  29b. Signature and title of pertifier  29c. License number  29a. Certifier  29c. License number  29d. Date signed (Month, Day, Year)   | cation;      | 1 Accident 5 Pending investigation   |  | of 28c. Injury at Work?  M 1 \[ Yes 2 \] No | 28d. Describe how                  | injury occurred  |
| (Check only 2   Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)   |              | 4 Homicide determined  | building, etc. (Specify)                                     |   | City or Town, S                    | State)   |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  TARIGO MATMOUN) 201-109 Reade River Neck Hall Read management.   | Medic        | (Check only 2   Medical Exam   | iner: On the basis of examination and/or                     | 29c. License number                         | curred at the time, date           | and place, and due to the cause(s)  Date signed (Month, Day, Year) |
|  |              |  |  | e, Print)  G Radic Niver                    | - Neck 1                           | 2d Rathemas  |

|                            |  |                 | 1 - For<br>State<br>Registrar   | Sta                            | ate of M                                 | arylan           |                                | artmen<br><i>rtificat</i>   |                           |              | and M           | ental Hy                      | gien<br>Reg. N |                            | 41831   |
|----------------------------|--|-----------------|---|--------------------------------|--|------------------|--------------------------------|-----------------------------|---------------------------|--------------|-----------------|-------------------------------|----------------|----------------------------|---|
|                            |  |                 | Decedent's Name (First, Midd  | le, Last)                      |  |                  |                                |                             |                           |              | 1               | 2. Date of De                 | ath            |                            | 3. Time of Death                                |
| В                          | Physici<br>/Medi   |                 | David E. Ma   | tzke                           |  |                  |                                |                             |                           |              |                 | Month<br>December             |                | y Year 2005                | 12:25 P <sup>M</sup>                            |
| 10                         | Examir   |                 | 4a. Facility Name (If not institution   | n, give street                 | and number)                              |                  |                                | 4b. City,                   | Town, or                  | Location of  |                 | December                      | 1.             | c. County of Dea           |   |
|                            |  |                 | Shady Grove Ad  | ventis                         | t Hosp                                   | ital             |                                | Roc                         | kvil                      | le           |                 |                               | M              | lontgome:                  | ry  |
| 0.5                        | Funeral  | 4.7             | 5. Social Security Number   | 6. Sex                         |  | e (In yrs.       | last birthday)                 | If Under<br>Months          | 1 Year<br>Days            | If Under     | 24 Hrs.<br>Min. | 8. Date of Bir<br>(Month, Da  | th             | 9 Rin                      | thplace (State or Foreign                       |
| а                          | Director   |                 | 396-26-3965   | 1 <b>X</b> 0 M 2               | 2   F                                    | 77               | Yrs.                           | WOTTI                       | Days                      | Hours        | WIII.           | Decembe:                      | r 6,           | 1928 Wis                   | consin  |
|                            | and w  |                 | Usual Residence of Decedent  10a. State 10b. Count  | ,                              |  | 10c Cit          | y, Town or Lo                  | cation                      |                           |              |                 |                               |                |                            | 404 1   |
|                            | Aaryl.   | ō               |   | gomery                         |  |                  | omac                           | ,041,011                    |                           |              |                 |                               |                |                            | 10d. Inside City Limits 1 ☐ Yes 2 🕅 No          |
|                            | 28a-   | Director        | 10e. Street and Number  | 50mery                         |  | 100              |                                | 10f. Zip                    | Codo                      |              |                 |                               | 10- 0          | Name of 1875 - 1 C         |   |
|                            | with with  |                 | 8209 Lochinve   | 4 Tana                         |  |                  |                                |                             |                           |              |                 |                               |                | itizen of What Co          |   |
|                            | ne 23  | era             | 11. Marital Status  |                                | as Decedent                              | Ever in U.       | S 13 1                         |                             | 0854                      | snanic Orio  | nin? (Sne       | cify Yes or No                |                | ted Stat                   |   |
| (0                         | riten  | Funeral         | 1 ☐ Never Married 2 🕅 Mar   | Δ.                             | mod Forces?                              |                  |                                | f Yes, spec                 | rfy Cubar                 | n, Mexican   | , Puerto f      | Rican, etc.)                  |                | Black, Whit                |   |
| 9                          | al', o   | by              | 3 ☐ Widowed 4 ☐ Divorces  | d Ye                           | XYes 2 ☐ !<br>Yes, Give<br>ear or Dates: | Korea<br>Confl   | in<br>Lict                     | 1 ☐ Yes                     | 2X No                     | Specify:     |                 |                               |                | Specify: W                 | nite  |
| 5-0                        | 72 ho  | Completed       | 15. Deceder<br>(Specify only highe  | nt's Education                 | 1  | 00111            | 16a. Dece                      | dent's Usua                 | l Occupa                  | tion         |                 |                               | 16b. l         | Kind of Business           | /Industry                                       |
| 21                         | thin 7   | ple             | Elementary/Secondary (0-12)   |                                | ollege (1-4or 5                          | 5+)              | life. i                        | kind of wor<br>DO NOT us    | rk done di<br>se retired) | uring most   | of workir       | ig                            |                |                            |   |
| 2                          | yd wi  | Con             |   |                                | 5+                                       |                  | Eng                            | ineer                       |                           |              |                 |                               | Е              | ngineeri                   | ing   |
| nd                         | be filed Hy d oth  | Be              | 17. Father's Name (First, Middle,   | Last)                          |  |                  |                                |                             |                           | 18. Mothe    | r's Name        | (First, Middle,               | Maidei         | n Sumame)                  |   |
| yla                        | Men<br>Men<br>arke   | ဥ               | Walter Matzke   |                                |  |                  |                                |                             |                           |              |                 | antman                        |                |                            |   |
| Maryland 21215-0036        | 2 sh<br>and<br>Is m  |                 | 19a. Informant's Name/Relations   |                                | rint)                                    |                  |                                |                             |                           |              |                 |                               |                | or Town, State, 2          | Zip Code)                                       |
|                            | and<br>lealth<br>m 27<br>her to  |                 | Jean Matzke/wi  | ie                             |  |                  |                                |                             |                           |              |                 |                               |                | aryland                    | 20854   |
| 0                          | pes 1<br>t of H<br>if ite<br>or ot   |                 | 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation   | 3 □Remov                       | al from State                            | 20b. P           | lace of Dispo<br>emetery, crer | sition (Nam<br>natory or of | ne of<br>ther place       | D            | ecemb           | er 24,                        | 20c. L         | ocation - City or          | Town, State                                     |
| Ē                          | Fattent:   |                 | 4 Donation 5 Other (5   | Specify)                       |  | Mont             | tgomery                        | Cremat                      | torium                    | n            | 2005            | 5                             | Bet            | hesda, N                   | Maryland  |
| Baltimore,                 | permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mentel Ptyglene. Important: if item 27 is marked other than "natural", or iteme 23s or 28s-1 show any follury or other traumatic event, the Medical Expirit an miss bur critical at ΩΩCε. |                 | 21. Signature of Funeral Service  | Kicensee                       | 4  |                  | Ro                             | bert A                      | Address<br>Pu             | of Facility  | y<br>Fune       | eral Hom                      | e, F           | ockville,                  | Inc.  |
|                            | 20 E e q   |                 | munch a.  | anopu                          |  | M0117            | 3 30                           | 00 W.                       | Montg                     | omery        | Avenu           | ie, Rock                      | vill           | e, MD, 20                  |   |
| П                          |  |                 | 23a. Part1. Enter the disease, o shock, or heart failure. List  | r complication<br>only one cau | s that caused<br>so on each lin          | the death<br>ne. | n. Do not ent                  | er the mode                 | of dying                  | , such as    | cardiac or      | respiratory ar                | rest,          |                            | Approximate<br>Interval Between                 |
|                            | Physician  |                 | Immediate Cause (Final disease or condition   | _ a.                           | Lung C                                   | ance             | r                              |                             |                           |              |                 |                               |                |                            | Onset and Death Year                            |
|                            | /Medical<br>Examiner   |                 | resulting in death)   |                                | Due to (or as                            | a consequ        | uence of):                     |                             |                           |              |                 |                               |                |                            |   |
| 720                        | 20   | _               | Sequentially list conditions,   | b                              |  |                  |                                |                             |                           |              | _               |                               |                |                            |   |
|                            | ed sit   | Examiner        | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | ł                              | Due to (or as                            | a consequ        | Jence of):                     |                             |                           |              |                 |                               |                |                            |   |
| _                          | and<br>I-tran  | хап             | that initiated events<br>resulting in death) Last   | c                              | Due to (or as                            | a consequ        | ience of                       |                             |                           |              |                 |                               |                |                            |   |
| 8760,                      | cate be executed<br>physicien and<br>the burial-transit  | a E             |   |                                | Dao 10 (01 as                            | a consoqu        | 361106 01).                    |                             |                           |              |                 |                               |                |                            |   |
| 387                        | phys<br>the  | dlcal           |   | d                              |  |                  |                                |                             |                           |              |                 |                               |                |                            |   |
| 9 X                        | The law requires that the death certificate be executed tie has been signed by the ettending physicien and bage 2 should be detached for use as the burial-transit   | by Physician/Me | IF FEMALE:  | 23c. If v                      | yes, outcome                             | of pregna        | ncv                            |                             |                           |              |                 |                               |                |                            |   |
| . Box                      | eath<br>etter<br>for u   | clan            | 23b. Was decedent pregnant in the past 12 months?   | 10                             | □Live birth<br>□Pregnant at              | 2 Fetal          | death 3                        | Ectopic pre                 |                           |              |                 |                               |                | 23d. Date of deli<br>Month | ivery<br>Day Year                               |
| О.<br>О.                   | that the de<br>led by the e<br>detached t  | iys             | 1 □ Yes 2 □ No<br>9 □ Unknown   |                                | Unknown                                  | tario di de      | Julii 3                        | Outer (spe                  | y)                        |              |                 |                               |                |                            |   |
| ٣.                         | that<br>led b<br>deta  | 4               | Part II. Other significant conditi  | ons contributi                 | ing to death b                           | ut not resu      | ılting in the ur               | nderlying ca                | use giver                 | n in Part I. |                 | 23e. Did to                   | bacco          | use contribute to          | the cause of death?                             |
| ds                         | puires than signed lid be det  | P               | Coronary Arter  |                                |  |                  |                                |                             |                           |              |                 | 1 🔼 Y                         | 'es 2          | □No 3 □ Pro                | obably 4 🗍 Unknown                              |
| 00                         | w requir<br>been si<br>should  | Completed       | Chronic Obstru  | ctive                          | Pulmon                                   | arv I            | )iseas                         | ٥                           |                           |              |                 | 24- 145-                      |                | 045 146                    |   |
| Re                         | The lay<br>cete has<br>page 2  | m d             |   |                                |  |                  |                                |                             |                           |              |                 | 24a. Was autop                |                | prior to death?            | topsy findings available completion of cause of |
| ā                          |  | ပိ              | 25. Was case referred to medica   |                                |  |                  |                                |                             |                           |              |                 | 1 Yes                         | 2 <b>∑</b> No  |                            | 2□ No   |
| 5                          | ysicien:<br>iis certifica<br>director, I   | ToB             | examiner?  1 Yes 2 No   | Hospita                        | al:<br>1 ⊠ Inpatie                       | nt 2 🗆           | ER/Outpatien                   | t 3□ DO/                    | Other                     | _            |                 | (Check only or                |                |                            |   |
| Division of Vital Records, | Attending Physicien: r death. ector: After this certific by the funeral director,  |                 | 27. Manner of Death   | 28a                            | a. Date of Injur                         | ry               | 28b. Time of                   |                             | Bc. Injury a              | at at        |                 | e 5 ☐ Hesid<br>Bd. Describe h |                | 6 Other (Spec              | cify)   |
| 0                          | ath.<br>r: Aft   | at o            | 1 Natural 5 ☐ Pendir<br>2 ☐ Accident investi  |                                | (Month, Day                              | (Year)           | Injury                         | м                           | Work?                     | es 2∐N       |                 |                               |                |                            |   |
| <u>N</u>                   | or Attendin<br>after death.<br>Director: Af<br>in by the fur   | ertification:   | 3 ☐ Suicide 6 ☐ Could<br>4 ☐ Homicide determ  | not be 28e                     | . Place of Inju                          | ıry - At ho      | me, farm, stre                 | eet, factory,               | office                    |              | 21              | Bf. Location (S               | Street ar      | nd Number or Ru            | ral Route Number,                               |
|                            | s after<br>s after<br>of Dire  | Cert            | 4   Homicide  |                                | building, etc                            | : (Specify       | ")                             |                             |                           |              |                 | City or Tow                   | m, State       | )                          |   |
|                            | To the Hospitel or within 24 hours afte To the Funerel Dir bompletely filled in I  |                 | 29a. Certifier 1 Certifyii  | g Physician:                   | To the best of                           | of my know       | wledge, death                  | occurred a                  | it the time               | , date and   | place, ar       | nd due to the o               | ause(s         | and manner as              | stated.   |
|                            | To the H<br>within 24<br>To the F<br>Somplete  | Medical         | one)  | ar                             | nd manner sta                            | ted.             | ion and/or inv                 | estigation,                 | in my opi                 | nion, death  | n occurre       | d at the time, o              | date and       | d place, and due           | to the cause(s)                                 |
|                            | To the<br>Within<br>To the   | 2               | 29b. Signature and the of contrie   |                                | 1 1                                      |                  | 1.                             | 29c.                        | License                   | number       |                 | 2                             | 29d. Da        | te signed (Month           | , Day, Year)                                    |
|                            |  |                 | certt-  | 120                            | rele                                     | u /              | Mos.                           | D2                          | 26540                     | )            |                 |                               | Dec            | ember 23                   | , 2005  |
| 16                         | 1/4  |                 | 30. Name and address of person  |                                |  |                  |                                |                             | _                         |              |                 |                               |                |                            |   |
| 1-                         |  |                 | Carl I. Schoen  |                                | 1111                                     |                  |                                | derick                      | k Roa                     | id, #        | 213,            | Gaithe                        | rsb            | urg, MD                    | 20877-4017                                      |
|                            | Sta<br>Registr   |                 | 31. Date filed (Month, Day, Year)   | 0 2005                         | 32. Registra                             | ar's Signat      | ure //                         | back                        | ,                         |              |                 |                               |                |                            |   |
| 17.50                      | riegisti   | 21              | UEU 2   | 0 5000                         | 100                                      | 1000             | 10                             |                             |                           |              |                 |                               |                |                            |   |

|              |   |                     | For State Registrar  | State of Marylan   | d / Depa                         |   | lealth and I   | Mental Hy                                  | -   | 41832  |
|--------------|---|---------------------|--|--|----------------------------------|---|--|--|---|--|
| H            | Physicia<br>/Medic  |                     | 1. Decedent's Name (First, Middle, Last)  Irene Sterling McI   |  |                                  |   |  | 2. Date of Dea<br>Month<br>Decembe         | Day Year 25, 2005                                 | 3. Time of Death 10:52 A. M                        |
|              | Examin  | er                  | 4a. Facility Name (If not institution, give s  |  |                                  |   | r Location of Deatl                                  | n  | 4c. County of Deat                                |  |
|              | Funeral   |                     | 5109 Bradley Bouley 5. Social Security Number 6. Sex   | 7. Age (In yrs. i  | last birthday)                   | Chevy Cl  | If Under 24 Hrs.                                     | 8. Date of Birtl                           | Montgomer   | ·  |
| ı.           | Director  |                     | 515-16-3684 Usual Residence of Decedent  | M 2⊠F 92   | Yrs.                             | Months Days   | Hours Min.   | 8. Date of Birtl<br>(Month, Da)<br>July 22 | , 1913 Kan  | thplace (State or Foreign<br>buntry)<br>S & S      |
|              | a-f show  | ctor                | 10a. State 10b. County Maryland Montgomer  |  | y, Town or Lo<br>vy Cha          |   |  |  |   | 10d. Inside City Limits<br>1 ☐ Yes 2 No            |
|              | or 28   | Dire                | 10e. Street and Number   |  |                                  | 10f. Zip Code   |  |  | 10g. Citizen of What Co                           | ountry?  |
|              | s 238   | erai                | 5109 Bradley Bouley  |  | e   123                          | 20815   | lianania Origina (C                                  |  | United Stat                                       |  |
| 036          | n 72 hours after death with the Marylan<br>"natural", or Itams 23a or 28a-1 show<br>select Extra in ar mant he multihad at                                      | by Funeral Director | 11. Marital Status  1 □ Never Married 2 □ Married  3 ☑ Widowed 4 □ Divorced  | 2. Was Decedent Ever in U.<br>Amed Forces?<br>1 ☐ Yes 2 ☒ No<br>If Yes, Give<br>Year or Dates:                 | i i                              | Was Decedent of H<br>f Yes, specify Cuba<br>1 ☐ Yes 2 ☑ No    | ispanic Origin? (S<br>an, Mexican, Puert<br>Specify: | pechy Yes or No-<br>o Rican, etc.)         | 14. Race - Ame<br>Black, Whit<br>Specify: W       | e, etc.  |
| 9500-61212   |   | Completed           | 15. Decedent's Educ<br>(Specify only highest grade<br>Elementary/Secondary (0-12)  | cation<br>completed)<br>College (1-4or 5+)<br>5+   | (Give<br>life.                   | dent's Usual Occup<br>kind of work done<br>DO NOT use retired | eation<br>during most of wor<br>d)                   | king                                       | 16b. Kind of Business<br>Montgomer                | y County   |
| 7            | filed within<br>Hygiene.<br>other than<br>rent, tre M   |                     | 17. Father's Name (First, Middle, Last)  | 5+   | Teac                             | ner   | 18 Mother's Nar                                      | ne /First Middle                           | Public Sc   | nools  |
| Maryland     | d be f  | To Be               | David Williams Ste   | rling  |                                  |   | Notie B  |  | walden Sumame)                                    |  |
| <u>چ</u>     | es 1 and 2 should be<br>of Health and Menta<br>f item 27 Is marked<br>r othar traumatic ev  | F                   | 19a. Informant's Name/Relationship (Type   |  | 19b. Mailir                      | ng Address (Street  |  |  | er, City or Town, State, 2                        | Zip Code)  |
|              | and 2<br>ealth a<br>n 27 is   |                     | Julianne McDonald/   | Daughter   | 7506                             | Albemarl  | e Drive,   | Manassas                                   | s, VA. 2011                                       | 1  |
| o<br>G       | es 1 a<br>of He<br>of He<br>fitem<br>roths  |                     | 20a. Method of Disposition 1   Burial 2 □ Cremation 3 □ Record 1   |  | lace of Dispo                    | sition (Name of   | Θ) Janu  | ary 4,                                     | 20c. Location - City or                           | Town, State  |
| Ě            | Pag<br>ment<br>ant: F   |                     | '4 □Donation 5 □ Other (Specify)   | amovat nom State   | Cemet                            | ery   | 20   | 006  | Arlington,  | Virginia   |
| Baltimore,   | permit, Pages 1 s Department of He Important: If item any injury or oth   |                     | 21. Signature of Funeral Survice License   | MO13   | 53 Be<br>Be                      | Name and Addre<br>thesda-Cl<br>thesda, N                      | ss of Facility Col.<br>nevy Chas<br>Iaryland         | ert A. I<br>se, Inc.<br>20814-35           | umphrey Fu<br>7557 Wisco<br>501                   | neral Home/<br>nsin Avenue                         |
|              | Physician<br>/Medical   |                     | 23a. Part1. Enter the disease, or complic shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)            | cations that caused the death e cause on each line.  Due to (or as a consequence)                              | rotic                            | 1   | og, such as cardiac                                  | /  | d Isease  | Approximate<br>Interval Between<br>Onset and Death |
| ,/60,        | ate be executed was nysician and he burial-transit  | Ical Examiner       | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | Due to (or as a consequence to (or as a consequence)   |                                  |   |  |  |   |  |
| O. Box 68    | The law requires that the death certifica<br>te has been signed by the attending ph<br>page 2 should be detached for use as th                                  | Physician/Medi      | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown  | 3c. If yes, out <i>co</i> me of pregna<br>1 ☐Live birth 2 ☐ Fetal<br>4 ☐ Pregnant at time of do<br>9 ☐ Unknown | Ideath 3                         | Ectopic pregnancy   | ,  | _  | 23d. Date of del<br>Month                         | ivery<br>Day Year                                  |
| ecords, P.   | w requires that<br>been signed b<br>should be deta  | þ                   | Part II, Other significant conditions con  | tributing to death but not resi  | ulting in the u                  | nderlying cause giv   | en in Part I.  | 23e. Did to                                | obacco use contribute to                          | the cause of death?                                |
| $\mathbf{r}$ |   | Completed           |  |  |                                  |   |  | 24a. Was a autop perfor 1 \( \text{Yes} \) | sy prior to                                       | atopsy findings available completion of cause of   |
| Vital        | sictan: The<br>certificate<br>rector, pag   | Be                  | 25. Was case referred to medical examiner?   | ospital:   |                                  | 044   |  | ath (Check only or                         | ne)   |  |
| ō            | ding Phys<br>h,<br>After this<br>funeral dir  | tion; To            | 27. Manper of Death  1 Natural 5 Pending   | 1 ☐ Inpatient 2 ☐<br>28a. Date of Injury<br>(Month, Day Year)  | 28b. Time of<br>Injury           | 28c. Injur<br>Wor   | y at   |  | lence 6 Other (Spectow injury occurred            | cify)  |
| Division     | To the Hospital or Attending Physician: within 24 hours alter death. To the Funeral Director: After this certific completely filled in by the funeral director, | Certification;      | 2 Accident investigation 3 Suicide 6 Could not be determined   | 28e. Place of Injury - At ho<br>building, etc. (Specity  | ome, farm, str                   |   |  | 28f. Location (S<br>City or Tow            | Street and Number or Ru<br>m, State)              | ıral Route Number,                                 |
|              | To the Hospital or within 24 hours af To the Funeral D completely filled in   | edical C            | 29a. Certifier 1 Certifying Phys (Check only one) 2 Medical Examin   | ician: To the best of my kno<br>er: On the basis of examina<br>and manner stated.                              | wledge, death<br>tion and/or in- | n occurred at the tirvestigation, in my o                     | me, date and place<br>pinion, death occu             | e, and due to the corred at the time, co   | cause(s) and manner as<br>date and place, and due | stated.<br>to the cause(s)                         |
|              | To the Comp   | ğ                   | 29b. Signature and title of certifier  | Q 41.  | 4.0                              | 29c. Licens   |  | 2  | 29d. Date signed (Monti                           | h, Day, Year)                                      |
|              | 0   |                     | fatucia lons   | sko rug,   | most                             | D   | 51916  |  | Dec, 27,  | 2005   |
| 15           |   |                     | 30 Name and address of person who con  | Nay, 11119   | Rocki                            | Print), Pik   | e, G-1   | O, Rock                                    |   | D 20852  |
|              | Sta<br>Registr  |                     | 31. Date filed (Month, Day, Year) DEC 2 8 20   | 32. Aecetrar's Signa   | ture                             | park.   | /  |  |   |  |

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ORIGINAL

|         |                   |  |                | For State  | State                                |                          |                              | / Depa                       | artmen                    | t of H              |                                 | d Mental I                             | lygier                | ) e                     |                         | 110  | 0.0                  |
|---------|-------------------|--|----------------|--|--------------------------------------|--------------------------|------------------------------|------------------------------|---------------------------|---------------------|---------------------------------|--|-----------------------|-------------------------|-------------------------|--|----------------------|
|         |                   |  |                | Registrar  |                                      |                          |                              | Cei                          | rtificate                 | e of I              | Death                           | 2. Date of                             | Reg. I                | 6.0                     | UJ                      | 4 1 0                                      | 33                   |
|         |                   | Physici  | an             | Decedent's Name (First, Middle   |                                      |                          |                              |                              |                           |                     |                                 | Month                                  |                       | Day                     | Year                    | 3. Time of                                 |                      |
|         |                   | /Medic   | al             | Milton A. Ma. Facility Name (If not institution  |                                      | umbarl                   | <del></del>                  |                              | 4h City                   | Town or             | Location of D                   | Decei                                  |                       | <del>-</del>            | 2005<br>by of Death     | 0930                                       |                      |
| •       | 1                 | Examin   | er             |  |                                      | iumo <del>o</del> r)     |                              |                              |                           | heso                |                                 | 54(1)                                  |                       |                         | gomei                   |  |                      |
|         | _                 | Cupaval  |                | Suburban Hosp:<br>5. Social Security Number  | 6. Sex                               | 7. Age                   | (In yrs. la:                 | st birthday)                 | If Under                  | 1 Year              | If Under 24                     |  |                       |                         |                         | - <u>y</u><br>place (State o<br>ntry)      | r Foreign            |
|         |                   | Funeral<br>Director  |                | 063-22-7646  | 1 <b>X</b> M 2□ F                    |                          | 77                           | Yrs.                         | Months                    | Days                | Hours N                         | Ain. (Month,                           | 2, 1                  | 928                     |                         | York                                       |                      |
|         |                   | P.   |                | Usual Residence of Decedent  |                                      |                          | 10a City                     | Town or Lo                   |                           |                     |                                 |  |                       |                         |                         | 10d. Inside Cit                            | h. Limite            |
|         |                   | aryla<br>•hov  | _              | 10a. State 10b. County   |                                      |                          |                              |                              |                           |                     |                                 |  |                       |                         |                         | 1 [X] Yes                                  |                      |
|         |                   | he M   | Director       | Maryland Monts  10e. Street and Number   | gomery                               |                          | Roc                          | kvill                        | .e<br>10f. Zip            | Code                |                                 |  | 10a                   | Citizen of              | What Cou                | ntry?                                      |                      |
| _       |                   | with   | 굽              | 1058 Pipestem I  | 21 000                               |                          |                              |                              |                           | 20854               |                                 |  |                       |                         | State                   |  |                      |
| \$      |                   | me 23  | Funeral        | 11. Marital Status   | 12. Was De                           | ecedent E                | ver in U.S                   | . 13.                        |                           |                     |                                 | ? (Specify Yes or uerto Rican, etc.    |                       | 14. Ra                  | ce - Ameri              | can Indian,                                |                      |
| 7       | 9                 | after o  | Ē              | 1 Never Married 2 Mar  |                                      | Forces?<br>s 2∭N<br>Give | 0                            | ŀ                            | it tes, speo<br>1 ⊟ Yes   |                     |                                 | ueno Alcan, etc.                       |                       | Speci                   | ack, White              | , etc.                                     |                      |
| 0930 AM | 21215-0036        | within 72 hours after deeth with the Maryland<br>ene.<br>than "natural", or iteme 23e or 28e-f ehow<br>he Madical Examiner must be collised at   | و              | 3X Widowed 4 □ Divorce   | Year or                              | Dates:                   |                              |                              |                           |                     |                                 | <u>.</u>                               |                       |                         | Wh:                     | ite  |                      |
| 6       | 5-                | nati.  | Completed      | 15. Deceder<br>(Specify only highe   | nt's Education<br>est grade complete | d)                       |                              | 16a. Dece<br>(Give           | dent's Usua<br>kind of wo | al Occup<br>rk done | ation<br>during most of<br>d)   | working                                | 1                     |                         | Business/Ir<br>  Stat   | -  |                      |
| 0       | 121               | withir<br>ane.<br>than   | d m            | Elementary/Secondary (0-12)  | College<br>5+                        | (1-4or 5⊣                | +)                           |                              | omist                     |                     | "                               |  |                       |                         |                         | of Def                                     | ense                 |
| (2)     | d 2               | Hygin Hygin ant.   |                | 17. Father's Name (First, Middle,  |                                      |                          |                              |                              |                           |                     | 18. Mother's                    | Name (First, Mid                       | _                     |                         |                         | 01 201                                     | CHBC                 |
| 0       | <u>a</u> n        | Mental<br>Mental<br>Med (  | To Be          | Jules C. Margo   | olis                                 |                          |                              |                              |                           |                     | Mild                            | red Sch                                | eibel                 |                         |                         |  |                      |
| 10      | Maryland          | shour<br>and N<br>mar  | -              | 19a. Informant's Name/Relation   | ship (Type, Print)                   |                          |                              | 19b. Maili                   | ng Address                | (Street             | and Number o                    | r Rural Route Nu                       | mber, Cit             | y or Town               | n, State, Zi            | p Code)                                    |                      |
| 124 105 | Z                 | s 1 and 2 should be filed within 72 hours after deeth with the Marylan f Health and Mental Hygiene. Item 27 is marked other than "natural", or Iteme 23e or 28e-f show other traumatic event. The Medical Examiner must be routilled at  |                | Laurie A.M. Ke   | esaris/Da                            | ught                     |                              |                              |                           |                     | Court,                          | Gaither                                |                       |                         |                         |  | 78                   |
| 1       | ore               | of He  |                | 20a. Method of Disposition 1 ☐ Burial 2 ☒ Cremation  | 3 □Removal fro                       | m State                  | Cel                          | ace of Dispo<br>metery, crea | matory or c               | ther plac           | De De                           | cember                                 | 20c.                  | Location                | - City or T             | own, State                                 |                      |
| 7       | Ë                 | Pag<br>ment<br>ant:  |                | 4 Donation 5 Other (   | Specify)                             |                          | Cre                          | tgome<br>mator               | ium,                      | Inc.                | 26                              | , 2005                                 | Be                    | these                   | da, M                   | arylan                                     | d                    |
|         | Baltimore,        | permit. Pages 1 and 2 should be filed Depertment of Health and Mental Hygis Important: If I lem 27 is marked other eny injury or other traumatic event.  |                | 21. Signature of Funeral Service   | Lice See                             |                          |                              | B                            | 2. Name ar<br>ethes       | d Addre<br>da-C     | ss of Facility<br>hevy Cl       | Robert A<br>hase In<br>nd 2081         | c. 7                  | mphr<br>557 I           | lisco                   | ineral<br>nsin A                           | Home/                |
| 7       |                   | 4020 d   |                | 222 Part Enter the disease   | r complications tha                  | t causad                 | M008                         | On not an                    | ethes                     | da,                 | Maryla:                         | nd 2081                                | 4-35                  | 01                      |                         | Approximat                                 | 0                    |
|         |                   |  |                | 23a. Part1. Enter the disease, of shock, or heart failure. List Immediate Cause (Final                     | _                                    |                          |                              |                              |                           |                     | <b>3</b> ,                      |  | ,                     |                         |                         | Approximate<br>Interval Bet<br>Onset and I | ween<br>Death        |
|         |                   | Physician /Medical   |                | disease or condition resulting in death)   | _ a                                  | eumoi                    | nla<br>a conseque            | ence of):                    |                           |                     |                                 |  |                       |                         | -                       |  |                      |
|         |                   | Examiner   |                |  |                                      | psis                     |                              |                              |                           |                     |                                 |  |                       |                         |                         |  |                      |
|         |                   |  | ner            | Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury | 0.                                   | •                        | a conseque                   | ence of):                    |                           |                     |                                 |  |                       |                         |                         |  |                      |
| 7       |                   | ocuted<br>nd<br>transi   | Examiner       | Cause (Disease or injury that initiated events resulting in death) Last                                    |                                      | cubi                     |                              |                              |                           |                     |                                 |  |                       |                         |                         |  |                      |
| 0       | 760,              | te be executed<br>ysicien and<br>se burial-transit   | ũ              | 1050likilg iii Godiiiy Edist   |                                      |                          | a conseque                   |                              |                           | _                   |                                 |  |                       |                         |                         |  |                      |
| 7       | 687               | cate t<br>physic   | dlcal          |  | d. Po                                | Tymy:                    | al la                        | Rheu                         | matic                     | a                   |                                 |  |                       |                         |                         |  |                      |
| 7       |                   | ding<br>ding   | /We            | IF FEMALE:<br>23b. Was decedent pregnant   | 23c. If yes,                         |                          |                              |                              |                           |                     |                                 |  |                       | 23d. D                  | ate of deliv            | /ery                                       |                      |
| I       | Box               | Jeath<br>etter   | Physiclan/Med  | in the past 12 months?   | 4□Pre                                | gnant at                 | 2 Fetal of dea               |                              | ⊒Ectopic p<br>⊒ Other (sp |                     | <u>'</u>                        |  | _                     |                         | onth                    |  | Year                 |
| 2       | 0                 | t the c<br>by the<br>achec   | hys            | 9 Unknown  | 9□ Un                                | known                    |                              |                              |                           |                     |                                 |  |                       |                         |                         |  |                      |
|         | S,                | beng<br>be del   |                | Part II. Other significant condit  | •                                    | death bu                 | ut not resul                 | lting in the u               | ınderlying o              | ause grv            | en in Part I.                   |  |                       |                         |                         | the cause of c                             |                      |
| 5       | ord               | equire<br>en sl  | ped            | Atrial Fibri   | llation                              |                          |                              |                              |                           |                     |                                 | _                                      | ∐ Yes                 | 2 X No                  | 3 ∐ Pro                 | bably 4 □l                                 | Jnknown              |
| 1-1     | ecord             | law ras be   | Completed by   | Hypothyroidis  | sm                                   |                          |                              |                              |                           |                     |                                 | 8                                      | Vas an<br>utopsy      |                         | prior to c              | opsy findings<br>ompletion of c            | available<br>ause of |
| 7       | <u>=</u>          | The cete h   | S              |  |                                      |                          |                              |                              |                           |                     |                                 | 1 🗆 Ý                                  | erformed<br>es 2 🕅    | No                      | death?                  | 2□ No                                      |                      |
| 0       | Z is              | iclan<br>certifi<br>ector  | Be             | 25. Was case referred to medic examiner?   | Manufali                             | S.F.                     |                              |                              |                           | Ott                 | or                              | Death Check o                          |                       |                         |                         | 1  |                      |
| 5       | <b>o</b> (        | Phys<br>r this<br>ral dii  | 5              | 1 ☐ Yes 2 🔯 No 27. Manner of Death   | 28a. Da                              | te of Injur              | rv                           | P/Outpatie                   |                           | 28c. Injui          | y at                            | ng Home 5 ☐ 1<br>28d. Desci            |                       |                         |                         | ity)                                       |                      |
| X       | O Lo              | ding<br>th.<br>: Afte<br>fune  | 늘              | 1 Natural 5 Pend<br>2 Accident inves   |                                      | lonth, Day               | Year)                        | Injury                       | м                         | Wor                 | k?<br>Yes 2∐No                  |  |                       |                         |                         |  |                      |
| MARGO   | Division of Vital | Atter  | Certification; | 3 ☐ Suicide 6 ☐ Could  | minor   200. Pla                     | ace of Inju              | ury - At hor<br>c. (Specify, | me, farm, st                 | reet, factor              | y, office           |                                 |  | on (Street            |                         | nber or Ru              | ral Route Num                              | iber.                |
| 2       | ۵                 | tal or<br>rs afte<br>at Dir  | Cert           |  |                                      |                          |                              |                              |                           |                     |                                 |  |                       |                         |                         |  |                      |
|         |                   | To the Hospital or Attending Physician: The law requires that the death certificat within 24 hours after death. Within 24 hours after death. Within Puneral Director: After this certificele has been signed by the ettending phy completely filled in by the funeral director, page 2 should be detached for use as the | edical         | (Check only 2 ☐ Medica   | ing Physician: To                    | the best of              | of my knov<br>examinati      | viedge, dea<br>ion and/or ir | th occurred               | at the ti           | me, date and p<br>pinion, death | olace, and due to<br>occurred at the t | the cause<br>me, date | e(s) and n<br>and place | manner as<br>e, and due | stated.<br>to the cause(s                  | à)                   |
|         |                   | the hin 2, the f   | Med            | one)  29b. Signature and title of certif   |                                      | anner sta                | ited.                        |                              | 29                        | c. Licens           | e number                        |  | 29d.                  | Date sign               | ned (Month              | , Day, Year)                               |                      |
|         |                   | Twit   |                | De dignature and the destin  | 1/100                                | de                       |                              | FAI                          |                           |                     |                                 |  |                       | _                       |                         |  | -                    |
|         |                   |  |                | 30. Name and address of pe   | n who completed o                    | ause of de               | eath (Item                   | 23a) (Type                   | Print)                    | D53                 | 691                             |  | D                     | ecemb                   | per 2                   | 4 2005                                     | >                    |
|         | 11                | ) "  |                | Ajay Reddy, M  |                                      |                          |                              |                              |                           | rd.                 | Bethes                          | da, Mary                               | land                  | 20                      | 817                     |  |                      |
|         |                   | St   | ate            | 31. Date filed (Month, D v, Yea  |                                      |                          |                              | -                            |                           |                     |                                 |  | NO CONTROL            | Post-Text               | mine of                 |  |                      |
|         | V.                | Regist   | rar            | DEC 2 8  | 3 2005                               | The second               | se the                       | ure<br>%                     | MARY.                     |                     |                                 |  |                       |                         |                         |  |                      |

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|               |  |                | 1 - For<br>State<br>Registrar   | State of N                              | /larylar             |                                  |                          |                          | lealth a<br>Death           | and M           |                                 | giene        | 1115               | 418                                     | 34         |
|---------------|--|----------------|---|---|----------------------|----------------------------------|--------------------------|--------------------------|-----------------------------|-----------------|---------------------------------|--------------|--------------------|---|------------|
|               |  | п              | 1. Decedent's Name (First, Middle, La   | st)                                     |                      |                                  |                          |                          | -                           | 1               | 2. Date of Dea                  | ath          |                    | 3. Time o                               | f Death    |
|               | Physici<br>/Medio  |                | Stefanos  | Mark N                                  | lavris               | 6                                |                          |                          |                             |                 | Month<br>Decembe                | r 27         | 2005               |   | АМ         |
|               | Examin   |                | 4a. Facility Name (If not institution, given  | re street and numbe                     | r)                   |                                  | 4b. City,                | Town, or                 | Location o                  | f Death         |                                 |              | County of De       |   |            |
|               |  |                | Manor Care Rux  | cton                                    |                      |                                  |                          | -                        | Towsor                      | n               |                                 | ł            | Bal                | timore                                  |            |
|               | Funeral  |                | Social Security Number     6.5  | Sex 7.7                                 |                      | last birthday)                   | If Under<br>Months       | 1 Year<br>Days           | If Under 2<br>Hours         | 24 Hrs.<br>Min. | 8. Date of Birt                 | h<br>v Year) |                    |   | or Foreign |
|               | Director   |                | 0/5-12-/3/2   | IM ZUF                                  | 95                   | Yrs.                             |                          | Duyo                     | 110015                      |                 | Jan. 20                         | , 19         | 10                 | irthplace (State<br>Country)<br>Greece  |            |
|               | and *  |                | Usual Residence of Decedent  10a. State 10b. County   |   | 10c Cit              | ty, Town or Lo                   | cation                   |                          |                             |                 |                                 |              |                    | 10d Innida C                            | Sha Limita |
|               | l sho  | ō              |   |   | 100.0                |                                  |                          |                          |                             |                 |                                 |              |                    | 10d. Inside C                           | 2 No       |
|               | the A  | Director       | Md. N/A   | \                                       |                      | Ra                               | ltimo                    |                          | Jity                        |                 |                                 |              |                    |   | 2 4100     |
|               | with with  |                |   |   |                      |                                  | 10f. Zip                 |                          | 1014                        |                 |                                 | Tug. Citi    | zen of What (      | Country?                                |            |
|               | leath<br>ns 23   | Funeral        | 3126 Weaver Av  | 12. Was Deceder                         | nt Ever in U         | S 13 1                           | Was Dono                 |                          | 1214                        | nin? /Sne       | ocify Vas os No                 |              | USA                | rerican Indian.                         |            |
| ^             | r Itan   | Ξ              | 1 ☐ Never Married 25 Married  | Armed Forces                            | s?                   | .0.                              | If Yes, spe              | cify Cuba                | n, Mexican,                 | Puerto F        | cify Yes or No-<br>Rican, etc.) |              | Black, Wh          |   |            |
| 3             | urs a  | by             | 3 ☐ Widowed 4 ☐ Divorced  | If Yes, Give<br>Year or Dates           |                      |                                  | 1 🗆 Yes                  | 2 No                     | Specify:                    |                 |                                 |              | Specify:           | White                                   |            |
| 15-0036       | be filed within 72 hours after death with the Maryland<br>la Hygiene.<br>d other than "neturel", or Itams 23e or 28e-f show<br>event, the Medical Examinat must be notified at | Completed      | 15. Decedent's E  | ducation                                |                      | 16a. Deced                       | dent's Usua              | al Occupa                | ation                       |                 |                                 | 16b. Ki      | nd of Busines      |   |            |
|               | thin and   | ρje            | (Specify only highest gri   | College (1-4o                           | r 5+)                | life.                            | DO NOT u                 | se retired               | during most<br>)            | or workii       | ng                              |              |                    |   |            |
| 7             | filed wi<br>Hygien<br>thar th  | ည်<br>မ        | 12  |   |                      |                                  | Pa                       | ainte                    | er                          |                 |                                 | Klic         | os Pai             | nting C                                 | 0.         |
| and           | d oth  | Be             | 17. Father's Name (First, Middle, Last  | )                                       |                      |                                  |                          |                          | 18. Mother                  | r's Name        | (First, Middle,                 | Maiden       | Sumame)            |   |            |
| >             | Men<br>Men<br>arke   | မ              | Mark  | Mavris                                  |                      |                                  |                          |                          |                             |                 |                                 | Mavr         |                    |   |            |
| Mar           | C1 d = dd  |                | 19a. Informant's Name/Relationship  | • |                      |                                  |                          |                          |                             |                 | l Route Numbe                   |              |                    |   |            |
| _             | s 1 and<br>f Health<br>itam 27<br>other tr   |                | Mrs. Evelyn M. Amt  | oridge/Dau                              |                      |                                  |                          |                          | ane [                       |                 | on, Mar                         |              |                    |   |            |
| 0             |  |                | 20a. Method of Disposition  1X Burial 2 Cremation 3   | Removal from Stat                       | 9 0                  | Place of Dispo<br>cemetery, cres | natory or o              | ther place               | ·                           |                 | ate                             |              | cation - City o    |   |            |
| <u> </u>      | tant:  |                | `4 □Donation 5 □Other (Special  | <b>5</b> )                              | St.                  |                                  |                          |                          | 1                           | 2/30/           |                                 |              |                    | Marylan                                 |            |
| Baltimore,    | permit. Page<br>Department of<br>Important: If<br>any Injury or<br>once.   |                | 21. Signature of Funeral Service Lice   | nsee                                    |                      | 22                               | . Name an                | nd Addres                | s of Facility               | Ruc             | ck Tows                         | on F         | uneral             | Home,                                   | Inc.       |
| _             | 0 □ = 6 O  |                | melayly   | 1 Trues                                 |                      |                                  |                          |                          |                             |                 | wson, M                         |              | and 21             | 204                                     | _          |
|               |  |                | 23a. Part1. Enter the disease, or com<br>shock, or heart failure. List only                                 | one cause on each                       | ed the deat<br>line. | h. Do not ent                    | er the mod               |                          |                             |                 | r respiratory ar                | rest,        |                    | Approximat<br>Interval Bet<br>Onset and | ween       |
|               | Physician  |                | Immediate Cause (Final disease or condition resulting in death)   | a. Ceru                                 | brur                 | usculo                           | س                        | A                        | ccibe                       | イト              |                                 |              |                    | Criset and                              | Dealli     |
|               | /Medical<br>Examiner   |                | <b>1</b>  | Due to (or a                            |                      | 1                                | 1 1                      | ١.                       | C A                         |                 |                                 |              |                    |   |            |
|               |  | 40             | Sequentially list conditions,   | b. Conve                                | Stiv                 |                                  | (1e~1                    | Υ                        | 1001                        | (2) }           |                                 |              |                    |   |            |
| 2             | ted<br>nslt  | Examiner       | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | Maria                                   | o d conseq           | udilos oi).                      | Jean)                    | h2                       | м.                          |                 |                                 |              |                    |   |            |
| 4             | be executed<br>ician and<br>burial-translt   | Exal           | that initiated events<br>resulting in death) Last   | c. Due to (or a                         | s a conseq           | uence of):                       | July 1                   | 1004-                    | 0 7                         |                 |                                 |              |                    |   |            |
| ۾/ <u>ه</u> ر | icate be executed<br>physician and<br>s the burial-translt   | dicail         | (   | d                                       |                      |                                  |                          |                          |                             |                 |                                 |              |                    |   |            |
| 20            | death certificate<br>e attending phys<br>of for use as the   | edic           |   | u                                       |                      |                                  |                          |                          |                             |                 |                                 |              |                    |   |            |
| X<br>Q<br>Q   | eath certific<br>attending p   | Physician/Me   | IF FEMALE:<br>23b. Was decedent pregnant  | 23c. If yes, outcom                     |                      |                                  | 200                      |                          |                             |                 |                                 | 2            | 3d. Date of de     | alivery                                 |            |
|               | deatl  | icia           | in the past 12 months?<br>1 □ Yes 2 □ No  | 1□Live birth<br>4□Pregnant              |                      |                                  | Ectopic pr<br>Other (sp  |                          |                             |                 |                                 |              | Month              |   | Year       |
| j.            | at the de<br>by the a<br>tached  | hys            | 9 Unknown   | 9∐ Unknown                              |                      |                                  |                          |                          |                             |                 |                                 |              |                    |   |            |
| Ś             | w requires that<br>s been signed b<br>should be deta   | by F           | Part II. Other significent conditions   | contributing to death                   | but not res          | ulting in the ur                 | nderlying c              | ause give                | n in Part I.                |                 | 23e. Did to                     | bacco u      | se contribute t    | to the cause of o                       | leath?     |
| cords         | en si<br>ould b  |                |   |   |                      |                                  |                          |                          |                             |                 | 1 🗆 Y                           | es 2[        | ]No 3 □ P          | robably 4 🗂                             | Inknown    |
| ပ္ပ           | S 0 0  | ompieted       |   |   |                      |                                  |                          |                          |                             |                 | 24a. Was a                      |              | 24b. Were a        | utopsy findings                         | available  |
| r             | The aate ha  | mo:            |   |   |                      |                                  |                          |                          |                             |                 | autop:<br>perfor                | med?<br>2 No | prior to<br>death? | completion of c                         | ause of    |
| <u>ra</u>     | slcian: The lar<br>certificate has<br>rector, page 2   | Be C           | 25. Was case referred to medical  |   |                      |                                  |                          |                          | 26. Place                   | of Death        | (Check only or                  |              | 1016               | 3 20140                                 |            |
| >             | S S S  | To             | examiner?<br>1 Ues 2 No   | Hospital: 1 🗆 Inpa                      | tient 2              | ER/Outpatien                     | t 3 DC                   | Othe                     | 4 D Nur                     | sing Hom        | ne 5 Resid                      | ence 6       | Other (Spe         | ecify)                                  |            |
| 10 U          | ng Ph<br>Iter th<br>neral  |                | 27. Manner of Death 1 Natural 5 ☐ Pending   | 28a. Date of In<br>(Month, D            | jury<br>av Year)     | 28b. Time of                     | 2                        | 8c. Injury<br>Work       |                             |                 | 8d. Describe h                  |              |                    |   |            |
| <u> </u>      | andin<br>sath.<br>or: Al   | atic           | 2 Accident investigatio   | n                                       |                      | ,,                               | М                        |                          | ′es 2□N                     | lo              |                                 |              |                    |   |            |
| UNISION       | r Att  | Certification: | 3 ☐ Suicide 6 ☐ Could not b<br>4 ☐ Homicide determined  |   | njury - At he        | ome, farm, stre                  | eet, factory             | , office                 |                             | 2               | 8f. Location (S. City or Town   | treet and    | Number or F        | lural Route Num                         | ber,       |
|               | ital c<br>irs af<br>ral D  |                |   |   |                      |                                  |                          |                          |                             |                 |                                 |              |                    |   |            |
|               | To the Hospital or Attanding Ph<br>within 24 hours alter death.<br>To the Funaral Director: Alter th<br>completely filled in by the funaral                                    | Medical        | Check only 2 Medical Exal   | ysician: To the bes                     | of examina           | wledge, death                    | occurred<br>restigation. | at the tim<br>, in my on | e, date and<br>inion, death | piace, a        | nd due to the c                 | ause(s)      | and manner a       | s stated.                               | )          |
|               | the hin 2 the mplet  | Ned            | Sile  | and manner                              | stated.              |                                  |                          |                          |                             |                 |                                 |              |                    |   | ,          |
|               | To To  | -              | 29b. Signature and title of certifier   |   |                      |                                  | 290                      | : License                | number                      | 001             | 2                               |              |                    | th, Day, Year)<br>- 20 V 5              | -          |
|               |  |                | 6//   |   |                      |                                  |                          | 7.3                      | 7                           | T               |                                 | 1 2          | > T                | ~ ~ . 7                                 |            |
|               | 10   |                | 30. Name and address of person who  | completed cause of                      | death (Item          | n 23a) (Type, I                  | Print)                   | in                       | 0.                          | 1.              | POI                             | m            | 2121               | 4                                       |            |
|               | -01  |                | 31. Date filed (Month, Day, Year)   | M 3 Renis                               | trar's Sinn          | US les                           | 1 3 Y                    | 1.0                      | 7~                          | 112             | 201                             | 1. 9         |                    |   |            |
|               | . Sta<br>Registr   |                | DFC 2 8 20  | 05                                      | المنكر ب             | A CO                             | W                        |                          |                             |                 |                                 |              |                    |   |            |

DHMH 17 Rev 1/2001

DECEMBER

MEALY,

| Physici  |                      | 1. Decedent's Name (First, Middle, Las   | 1)   | -                             |   |                                    | 2. Date of Deat                            | Day Year                                       | 3. Time of Dea<br>4:55P                    |
|--|----------------------|--|--|-------------------------------|---|------------------------------------|--|--|--|
| /Medic<br>Examin   | al -                 | Catherine Meade  4a. Facility Name (If not institution, give  3824 Deckerts L  |  |                               | 4b. City, Town, or<br>Baltim  | Location of Death                  | Decembe                                    | 4c. County of Deat                             |  |
| Funeral<br>Director  |                      | 5. Social Security Number 6. Se 11 214-14-7166   |  | vrs. last birthday)<br>4 Yrs. | If Under 1 Year<br>Months Days  | If Under 24 Hrs.<br>Hours Min.     | 8. Date of Birth<br>(Month, Day,<br>12/14/ | Year) 9. Birt                                  | hplace (State or Fo<br>untry)<br>ryland    |
| -f show<br>fied at   |                      | Usual Residence of Decedent  10a. State 10b. County  MD N/A  | 10c.   | City, Town or Lo              |   |                                    |  |  | 10d. Inside City □                         |
| 3a or 28s  | ā                    | 10e. Street and Number<br>3824 Deckerts La   | ne   |                               | 10f. Zip Code   | 236                                | 1.   | Og. Citizen of What Co                         | untry?                                     |
| lal Hygene. d other than "natural", or items 23a or 28a-1 show event, If e Modical Examiner must be notilied at  | Completed by Funeral | 11. Marital Status  1 □ Never Married 2 □ Married  3 □ Widowed 4 ☑ Divorced  | 12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:          |                               | Was Decedent of Hi<br>If Yes, specify Cuba<br>1 ☐ Yes 2 🔀 No                |                                    | ecify Yes or No-<br>Rican, etc.)           | 14. Race - Ame<br>Black, White<br>Specify: W   |  |
| nen "natura<br>y Violeal I   | npieted              | 15. Decedent's Ed<br>(Specify only highest grades)<br>Elementary/Secondary (0-12)  | ucation<br>de completed)<br>College (1-4or 5+)   |                               | dent's Usual Occupi<br>kind of work done o<br>DO NOT use retired            | ation<br>during most of work<br>f) | ing  | 16b. Kind of Business/                         |  |
| ental Hygier<br>ced other th   | To Be Cor            | 12 17. Father's Name (First, Middle, Last) John Oliver Bro   | wn   | Ca                            | ashier  | 18. Mother's Name                  | (First, Middle, M                          |  | er   |
| alth and Men<br>127 is marke<br>ar traumatic   | F                    | 19a. Informant's Name/Relationship (7 William Meade/So   |  |                               | ng Address (Street a  | and Number or Rura                 | A Route Number                             | ; City or Town, State, 2                       | Tip Code)                                  |
| popular I agos i stato snowbood not be popular in a good of Health and Mental Hygiene. Inpopularit if item 27 is marked other than any injury or other traumatic event, II s M. 2006.  |                      | 20a. Method of Disposition  1  | G  | ardens o                      | osition (Name of<br>matory or other place<br>of Faith<br>2. Name and Addres | 12/2<br>ss of Facility Mi          | 8/05<br>11er-Dip                           | Baltimore,<br>Dpel Funera<br>Maryland          | Marylar                                    |
| hysician and attenuate or executed the private and to the private are the private and to the private are the private as the private are the pr | cal Ex               | 23a. Part 1. Enter the disease, or come shock, or heart lailure istemly disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | Due to (or as a con  Due to (or as a con  Due to (or as a con  Due to (or as a con  d.     | asequence of):                | WN  | CARC                               | i NOM                                      | 4  | Approximate Interval Between Const. and De |
| ringstoam. The taw requires that the bean between<br>this certificate has been signed by the attending ph-<br>ral director, page 2 should be detached for use as th  | by Physician/Med     | IF FEMALE: 23b. Was decedent pregnant in the past 12 menths? 1 □ Yes 2 ☑ No 9 □ Unknown  | 23c. If yes, outcome of pre<br>1 □ Live birth 2 □ F<br>4 □ Pregnant at time<br>9 □ Unknown | Fetal death 3                 | □Ectopic pregnancy<br>□ Other (specify)                                     | ,                                  |  | 23d. Date of dei<br>Month                      | ivery<br>Day Ye                            |
| n signed build be deta   |                      | Part II. Other significant conditions of   | ontributing to death but not   | resulting in the u            | inderlying cause give   | en in Part I.                      |  | paccoluse contribute to<br>es 2 □ No 3 □ Pr    | /  |
| cate has been<br>page 2 should   | Completed            |  |  |                               |   |                                    | 24a. Was a autops perform                  | ned? prior to death?                           | topsy findings ava<br>completion of cau    |
| r this certificate<br>and director, pag  | To Be                | 25. Was case referred to medical examiner?  1  Yes  2 No  27. Manger of Death  | 28a. Date of Injury  | 2 ER/Outpatier                | 28c. Injun  | y at                               | me 5 Reside                                | e)<br>ence 6 Other (Spec<br>ow injury occurred | cify)                                      |
| Actor: After by the funer  | Certification:       | 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be determined   |  | At home, larm, str            |   | Yes 2 □ No                         | 28I. Location (St<br>City or Town          | reet and Number or Ru<br>n, State)             | ıral Route Numbe                           |
| after deatl  | O                    |  | ysicien: To the best of my<br>niner: On the basis of exam                                  |                               |   |                                    |  |  |  |
| ne nospital of Any<br>124 hours after d<br>ne Funeral Direct<br>pletely filled in by i   | dical                | one)   | and marrier stated.  |                               |   |                                    |  |  |  |
| within 24 hours after death.  To the Funeral Director: After th completely filled in by the funeral  | Medical              | 29b. Signature and tytle of confiller  | and meaner stated.   | D                             | 29c, Licenso  | 3409                               | 2  | 9d. Date signed (Month                         | n, Day-Year)                               |

Laurene Francis McMahon Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Unpend item# 23a,27 pen/E C351 1/11/06 TT tale of Maryland / Department of Health and Mental Hygiene 05-08671 RJFor State Registrar Certificate of Death 1-Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month Year **Physician** December 2005 11:40 p.<sup>M</sup> Laurene Francis McMahon /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Laurel Regional Hospital Laurel If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Ye 4/6/1956 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 1 □ M 2 1 F 043-60-2199 49 Connecticut Director Usual Residence of Decedent 10d. Inside City Limits the Maryland 10c. City, Town or Location 10a State 10b. County or items 23a or 28a-f show I Hygiene.
other than "natural", or Itema 23s or see.
vent, it s Medical Exeminat must be notified at 1 ☐ Yes 2 X No Director MD Beltsville Prince Georges 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number 20705 U.S.A. 10508 46th Avenue death Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Black, White, etc. 1 □Yes 2 ☑ No If Yes, Give Year or Dates: filed within 72 hours after 1 Never Married 2 Marned 1 ☐ Yes 2 No Specify: Baltimore, Maryland 21215-0036 Specify: White δ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Electrical Inspector State of Maryland 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Department of Heelth and Mental Hy Important: If Item 27 is marked othe any injury or other traumatic event, 90ce. 17. Father's Name (First, Middle, Last) Be Francis McMahon Patricia Maynard 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 10508 46th Avenue Beltsville, Maryland 20705 Christina M. Rheault 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 12/28/05 Metro Crematory Baltimore, Maryland 4 Donation 5 ☐ Other (Specify) 21. Si nature of Funeral Service Licensee 22. Name and Address of Facility Miller-Dippel Funeral Home Inc. 6415 Belair Road Baltimore, Maryland 21206 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Hypertensive Atherosclerotic Cardiovascular Disease Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Quarto (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of) P.O. Box 68760, Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No ō 4☐Pregnant at time of death 5 ☐ Other (specify) be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ۵ Records. 1 🗌 Yes 3 ☐ Probably 4 ☐ Unknown page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ▶ Yes 2 □ No 24a. Was an autopsy performed' 1 Yes 2 🗆 No Division of Vital funeral director. 25. Was case referred to medical 26. Place of Death (Check only one, Hospital: 1 ☐ Inpatient 2XXEP/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) XXYes 2 No Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation death. 2 Accident Director 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ģ 4 Homicide hours after within 24 hours aft To the Funeral Di completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) December 23, 2005 29b. Signature and title of certified 29c. License number OCME 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) III Penn Street Baltimore, Maryland 21201 MPPLEM 32. Registrar's Signature 31. Date filed (Month, Day, Year) State DEC 2 8 2005

Registrar

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day ROBERT A. NUSBAUM AM 25, 2005 DEC. 1:42 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death CARROLL WESTMINSTER SULLIVAN AVE. If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number Birthplace (State or Foreign Country) 1**⊠**M 2□F Months 13/1934 MARYLAND 220-26-5842 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County CARROLL WESTMINSTER 1X Yes 2 No 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21157 11 B SULLIVAN AVE. USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1 XYes 2 No If Yes, Give Year or Dates: 1956 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: WHITE 1962 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) PLUMBER CONSTRUCTION 6 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) HARRY A. NUSBAUM IDA E. MARTIN 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) KATHLINE NUSBAUM - WIFE 11 B SULLIVAN AVE., WESTMINSTER, MD. 21157 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition N Burial 2 ☐ Cremation 3 ☐ Removal from State LAKE VIEW MEM. PARK 12/28/05 ¹ 4 □ Donation 5 □ Other (Specify) ELDERSBURG, MD. 22. Name and Address of Facility FLETCHER FUNERAL HOME 21. Signature of Funeral Service Licens e 254 E. MAIN ST., WESTMINSTER, MD. 21157 23a. Part1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Ou YPOrs Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d, Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Lloknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 No 24a. Was an autopsy 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of

Examiner as the burial-transit The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760 attending physician esn Por detached should be has page 2 or Attending Physicien: ours after death.

erel Director: After this certific filled in by the funeral director.

by Physiclan/Medical Completed Certification: To Be

Medical

**Physician** 

/Medical

MD

Director

Funeral

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Completed

Be

Examiner

**Funeral** 

Director

7 is marked other than "natural", or Items 23a or 28a-f show treumatic svent, Ite Mudical Examinate rount be multiled at

permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene important: If Item 27 is marked other than "natural; or Item any injury or other treumatic svent, the Mudical Exercities and any

Pnysician

/Medical

Examiner

Baltimore, Maryland 21215-0036

with the Maryland

death

To the Hospitel within 24 hours a

State Registrar

29b. Signature and table of certifier

5 Pending investigation

6 Could not be

determined

1 Natural

2 Accident

3 ☐ Suicide

29a, Certifier

4 ☐ Homicide

(Check only one)

4/an 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) West

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

29c. License number

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

1 Tyes 2 No

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3 Time of Death 1. Decedent's Name (First, Middle, Last) Month Day Physician Helen 8:20 A N Nogle Decembe 26,2005 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** Westmins (10ME) NUSMA How Westmins If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 ☐ M 2 💢 F Yrs. 030-20-3761 92 Director MASSACHUSETTS 6/12/1913 Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County or 28e-f show or than "naturel", or items 23a or 28e-f show the Wedical Examinar roust by notified at 1 X Yes 2 No Director MONTGOMERY GAITHERSBURG 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number should be filed within 72 hours after death with nd Mental Hygiene. 28 WHETSTONE DR., APT. 20877 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black. White, etc. 1 □ Yes 2 ☑ No If Yes, Give Year or Dates: 1 XNever Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify: WHITE 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) NURSE HEALTH 12 4 of Health and Mental Hygie I item 27 is marked other r other treumatic event, II 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be FRANCIS S. NAGLE CLARA A. KELLY 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code), 0 8 1 4 19a. Informant's Name/Relationship (Type, Print) 4600 EAST-WEST HIGHWAY, SUITE 201, BETHESDA, MD -ATTORNEY JOHN J. DILLON Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a, Method of Disposition permit. Pages 1 Department of H importent: if itel any injury or oth remation 3 Removal from State COUNTY CREMATION 12/27/05 SYKESVILLE, MD. ALL 5 Other (Specify) \* 4 ☐ Donatio 22. Name and Address of Facility FLETCHER FUNERAL HOME Signatore Funeral Service Licensee 254 E. MAIN ST., WESTMINSTER, 21157 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or head failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (kinal disease or condition resulting in death) Myocardial are do Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner certificate be executed burial-tran Due to (or as a consequence of): physician Physician/Medical the use as the attending IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Year ģ Dav 4□Pregnant at time of death 5 ☐ Other (specify) o detached 9 Unknown 9 Unknown by ۵. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ۵ pe 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy certificate 2 No 1 ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Certification: To 1 🗌 Yes 2 □ ER/Outpatient 3□ DOA funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Injury 1 Natural 5 Pending .4 hours after death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital e within 24 hours at To the Funerel D 29a. Certifier to Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registr<u>ar</u> 31. Date filed (Month, Day, Year)
DEC 2 8 2005

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MO

MORI

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

30-

|  |                  | For Stete Registrar   | S                       | tate of                               | f Maryla                                     | ind / Dep<br><i>Ce</i>              |                                 | of H                  | ealth a                    |                        | •                                 | ygieņ<br>Reg. N                       | 21111                    | 5                       | 418                          | 10             |
|--|------------------|---|-------------------------|---------------------------------------|--|-------------------------------------|---------------------------------|-----------------------|----------------------------|------------------------|-----------------------------------|---------------------------------------|--------------------------|-------------------------|------------------------------|----------------|
| Physici  | an               | Decedent's Name (First, Middle  | , Last)                 |                                       | NT .   |                                     |                                 |                       |                            |                        | 2. Date of I                      | Death D                               | ay                       | Year                    | 3. Time o                    |                |
| /Medic<br>Examin   |                  | Maria 4a. Facility Name (If not institution   | ı, give stree           |                                       | Nestei<br>mber)                              | czuk                                | 4b. City, T                     | own, or               | Location of                | of Death               | Dec.                              | 24,                                   | 2005<br>c. County        | of Death                | 3:10                         |                |
| LXamii   |                  | St. John's (  | Commur                  | nitv                                  |  |                                     | В                               | alti                  | imore                      |                        |                                   |                                       | N/A                      |                         |                              |                |
| Funeral<br>Director  |                  | 5. Social Security Number 091–80–0423   | 6. Sex<br>1 ☐ M         |                                       | 7. Age (In yi<br>89                          | rs. last birthday<br>Yrs.           | Months                          | Year<br>Days          | If Under<br>Hours          | 24 Hrs.<br>Min.        | 8. Date of E<br>(Month,<br>5/30   | Birth<br>Day, Yea<br>/ 191            | 6                        | Coul                    | olace (State ontry)<br>raine | or Foreign     |
| Pu & US  |                  | Usual Residence of Decedent  10a. State 10b. County   |                         |                                       | 10c  | City, Town or L                     | ocation                         |                       |                            |                        |                                   |                                       |                          |                         | 10d. Inside C                | ity Limits     |
| Aanyla<br>f sho  | ō                | MD N/   | Δ                       |                                       |  | Baltimo                             |                                 |                       |                            |                        |                                   |                                       |                          |                         |                              | 2 No           |
| 28a-   | Funeral Director | 10e. Street and Number  |                         |                                       |  | Daretine                            | 10f. Zip (                      | Code                  |                            |                        |                                   | 10g. C                                | Citizen of V             | Vhat Cou                | ntry?                        |                |
| h with   | io e             | 16 S. Patterso  | n Par                   | k Ave                                 | enue   |                                     | 21                              | 1224                  |                            |                        |                                   |                                       | USA                      | \$                      |                              |                |
| deat   | ner              | 11. Marital Status  | 12.                     | Was Dece<br>Amed Fo                   | edent Ever in                                | U.S. 13.                            | Was Decede                      | ent of Hi             | spanic Ori                 | gin? (Spi              | ecify Yes or I<br>Rican, etc.)    | No-                                   |                          | e - Ameri               | can Indian,                  |                |
| itied within 72 hours after death with the Maryland Hygiene.  Whysiene.  Wher than "naturel; or items 23s or 28s-f show ont, the Medical Evaninational Learning or 18s-field at  | by FL            | 1 ☐ Never Married 2 ☐ Marri<br>3 ☐ Widowed 4 ☐ Divorced   |                         | 1 ∐Yes<br>If Yes, Giv<br>Year or D    | /8   | Approximately and the second        | 1 ☐ Yes Ž                       |                       | Specify:                   |                        |                                   |                                       | Specify                  | Whi                     | te                           |                |
| 2 hou ature  | ted t            | 15. Deceden   | t's Education           | on                                    |  | 16a. Dece                           | dent's Usual                    | Occupa                | ation                      | A = 6= w/s             | <i>i</i>                          | 16b.                                  | Kind of Bu               | ısiness/In              | dustry                       |                |
| thin 7   | Completed        | (Specify only higher Elementary/Secondary (0-12)  |                         | College (1                            | -4or 5+)                                     | lite.                               | DO NOT use                      | e retired             | iuring mos<br>!)           | t of work              | ing                               |                                       |                          |                         |                              |                |
| led wi   |                  | AZ Catada Nama /Fina Middle   |                         | 5                                     |  |                                     | Teache                          | er                    | 19 Moths                   | orla Niama             | e (First, Midd                    |                                       | Educa                    |                         |                              |                |
| uld be fil<br>Mental H<br>Irked oth  | To Be            | 17. Father's Name (First, Middle, Wasyl Mycak   | Last)                   |                                       |  |                                     |                                 |                       |                            |                        | Baczin:                           |                                       | en Surnam                | 10)                     |                              |                |
| 2 sho<br>and<br>ie mu  |                  | 19a. Informant's Name/Relations   |                         | Print)                                |  |                                     | ing Address                     |                       |                            |                        |                                   | -                                     |                          |                         |                              |                |
| Tand<br>Tand<br>Health   |                  | George Nesterc  20a. Method of Disposition  | zuk                     |                                       | 201  | 2013<br>D. Place of Disp            | Westv                           |                       | FOLE                       |                        | Date                              | _                                     | , VA.                    |                         |                              |                |
| ages<br>int of the   |                  | 1 ⊠ Burial 2 ☐ Cremation  1 ☐ Donation 5 ☐ Other (S   |                         | oval from                             | State  | cemetery, cre                       | matory`or otl                   | her plac              |                            |                        | 29/05                             |                                       |                          | -                       | Hudso                        | n NY           |
| politimity in the Marylan Color, in the Marylan permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: if Item 27 is marked other than "naturel; or Items 23a or 28a-f show any njury or other treumatic event, the Medical Examinat must be inclined at once.   |                  | 21. Signature of Funeral Service  |                         | 4                                     |  |                                     | 2. Name and                     | Addres                | s of Facilit               | ty Mi                  | iller-                            | Dipp                                  | el Fu                    | nera                    | 1 Home                       | Inc.           |
| 405.60   |                  | 23a. Part1. Enter the disease, or   | Complicati              | mis that o                            | aused the de                                 | eath Do not er                      |                                 |                       |                            |                        | or respirator                     |                                       | Maly                     | Land                    | Approxima                    |                |
| Dharistan  |                  | shock, or heart failure. Limitediate Cause (Final   | one c                   | ause on e                             | ach line.                                    |                                     |                                 |                       |                            |                        |                                   |                                       |                          |                         | Interval Be<br>Onset and     | tween<br>Death |
| Physician<br>/Medical  |                  | disease or condition resulting in death)  | a                       | Due to                                | (or as a cons                                | sequence of):                       | A AC                            | ندد                   | rent                       |                        |                                   |                                       |                          |                         | 1 Hr                         | •              |
| Examiner purification franching property propert | Examiner         | Se uentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated avents | b                       | Due to                                | or as a cons                                 |                                     | urdsu                           | verst                 | i Co                       | uzho                   | الله الله                         | w                                     | SER                      | we                      | 1041                         | -3             |
| ate be executed hysician and the burial-transit  | cai              | resulting in death) Last  | d                       | Due to                                | (or as a cons                                | sequence of):                       |                                 |                       |                            |                        |                                   |                                       |                          |                         |                              |                |
| death certific e attending point for use as it   | Physician/Med    | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No   |                         | 1 ☐ Live t                            | tcome of pre-<br>pirth 2 F<br>nant at time o | etal death 3                        | □Ectopic pre                    |                       |                            |                        |                                   |                                       |                          | te of deliv             | -                            | Year           |
| ords, F.C. Do<br>requires that the death<br>een signed by the atten<br>hould be detached for   | by               | Part II. Other significant conditi  | ons contrib             | outing to d                           | eath but not                                 | resulting in the                    | underlying ca                   | iuse givi             | en in Part I               |                        | ļ                                 |                                       | o use cont               |                         | the cause of                 |                |
| - Q 10   | ompleted         |   |                         |                                       |  |                                     |                                 |                       |                            |                        | 24a. W                            |                                       | 24b. \                   | Were auto               | opsy findings                | available      |
| <b>₽</b> 0 <u> □</u>   | mo.              |   |                         |                                       |  |                                     |                                 |                       |                            |                        |                                   | itopsy<br>informed2<br>s 2 <b>X</b> 1 | ?   (                    | death?                  | mpletion of o<br>2□ No       | ause of        |
| VICAL Fisiolan: The certificate rector, pag  | BeC              | 25. Was case referred to medica examiner?   |                         |                                       |  |                                     |                                 | 11.23                 |                            |                        | h (Check on)                      | (v one)                               |                          |                         |                              |                |
| this al di   | 2                | 1 ☐ Yes 2 No 27. Manner of Death  | Hosp                    | 1 🗀                                   |  | 28b. Time                           |                                 | A Othi                | er: 4 □ Nu                 | ursing Ho              | ome 5 Re                          |                                       |                          |                         | imed w                       | ilwy           |
| JIIII  | tlon             | Natural 5 Pendi   | ng<br>igation           | (Mon                                  | of Injury<br>th, Day Year                    | ) Injury                            | M                               | Bc. Injun<br>Worl     | k?<br>Yes 2 □              | No                     | 200. 0030112                      | ,0 110 11 11                          | ijury occuri             | 00                      |                              |                |
| DIVISION Jor Attending after death. I Director: After d in by the fune   | ertification:    | 3 Suicide - 6 Could 4 Homicide  | not be                  | 28e. Place<br>buildi                  | of Injury - A                                | at home, farm, s                    | treet, factory,                 | office                |                            | Ì                      | 28f. Location<br>City or          | n (Street<br>Town, Sta                |                          | er or Run               | al Route Nur                 | nber,          |
| pitel or<br>ours aft<br>erel Dif   | 0                |   |                         |                                       |  |                                     |                                 |                       |                            |                        |                                   |                                       |                          |                         |                              |                |
| To the Hospitel within 24 hours a To the Funerel C   | ledical          | 29a. Certifier 1 Certifyin (Check only 2 Medicel one)   | ng Physici<br>Exeminer: | : On the b                            | e best of my leasis of examiner stated.      | knowledge, dea<br>nination and/or i | ith occurred a<br>nvestigation, | at the tin<br>in my o | ne, date an<br>pinion, dea | nd place,<br>ath occur | and due to the<br>red at the time | he cause<br>ie, date a                | (s) and ma<br>and place, | inner as s<br>and due t | tated.<br>o the cause(       | 5)             |
| To th<br>withir<br>To th   | M                | 29b. Signature and title of certifie  |                         |                                       |  |                                     |                                 |                       | e number                   | _                      |                                   |                                       | _                        |                         | Day, Year)                   |                |
|  |                  | 1 Kanul   | Auch                    | f                                     |  |                                     | E.                              | 73.                   | الولو                      | 0                      |                                   | 17                                    | uemi                     | ner 2                   | كرور كمك                     | ジャラ            |
| 4  |                  | 30. Name and address of person  |                         | leted caus                            | se of death (                                | Item 23a) (Type                     | Print)                          |                       | . 0                        |                        |                                   |                                       | 2-7                      |                         |                              |                |
| 0  |                  | 31. Date filed (Month, Day, Year  | 90                      | \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ | Registrar's Si                               | gnature 2                           | 1700                            | re con                | ١                          | M                      | 2                                 | NU                                    | 70                       |                         |                              |                |
| Regist   | ate<br>rar       | DEC 2 8   |                         | 130                                   | Circa.                                       | t-tue-<br>gnature                   | SHEL                            |                       |                            |                        |                                   |                                       |                          |                         |                              |                |

DHMH 17 Rev 1/2001

**ORIGINAL** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** Regina E. Oleszczuk 2005 Dec 27, 6:55 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** 4b. City. Town, or Location of Death Baltimore ri Year | If Under 24 Hrs. 1712 Eastern Ave. n/a 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Min. 1 ☐ M 2 🕱 F Director 220-24-2892 76 10/20/ Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examinat must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 XYes 2 No Baltimore Md n/a 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1712 Eastern Ave. 21231 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Yes 2 X No Specify: Specify. 3 ₩Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 4 U Homemaker Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be unknown unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1712 Eastern Ave. Baltimore, Md. Stanley Oleszczuk, Jr. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ■ Burial 2 Cremation 3 Removal from State Holy Rosary Ceme. 12/29/05 4 ☐ Donation 5 ☐ Other (Specify) Dundalk, Md. 21. Signature of Funeral Service Licensee MOO 355 Racarados facilifuneral Home P.A. Cart 1201 Dundalk Ave. Baltimore, Md. 92 21222 23a. Part1. Ententhe disease, or Amplications that caused the reath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician DNO years disease or condition resulting in death) cancer /Medical Due to (or as sonsequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Causa (Discass of injury Physician/Medical Examiner Due to (or as a consequence of): The law requires that the death certificate be executed use as the burial-transit attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Month Year 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2 No be detached signed by the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown Mover 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performe certificate 1 ☐ Yes 1 Yes 2 4No 2 17 No or Attending Physician: funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: Medical Certification: To 1 ☐ Yes 2 ☐ Mo 2 ER/Outpatient 3□ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After this 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 5 Pending Injury 1 Natural death. 1 ☐ Yes 2 ☐ No 2 Accident investigation Director: filled in by the 6 Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide within 24 hours a To the Funeral L 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check only onel 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Registrar

State

31. Date file

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

601

52499

N. caroline St. Bultmore, MD 21287-094

27/2005

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32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

8 2005

NRS

|  |                  | For State   | <del>-</del> -  | ryland / Depa   |  |   | •  | ene   |                                      |
|--|------------------|---|---|---|--|---|--|---|--------------------------------------|
|  |                  | Registrar   | <del></del>   | Cei   | rtificate of   | Death                                   |  | g. No. UU5                                  | 4/843                                |
| Physici  | an               | Decedent's Name (First, Middle, Las.  | 1)  |   |  |   | 2, Date of Death<br>Month                      | Day Year                                    | 3. Time of Death                     |
| /Medic   | cal              | Ann Rita Owens  4a. Facility Name (If not institution, give   | atrast and sumbas   |   | 4h City Town   | or Location of Dea                      | December                                       |   |                                      |
| Examir   | ıer              | Manor Care Rossy  |   |   | Rossvi   |   | ın   | 4c. County of Dea                           |                                      |
| Funeral  | 20 4             | Social Security Number  |   | (In yrs. last birthday)                                 | If Under 1 Year  | If Under 24 Hrs                         |  |   | Te thplace (State or Foreign ountry) |
| Director   |                  | 219-16-3571 10<br>Usual Residence of Decedent   | □M 2K□F   | 83 Yrs.   | Months Days  | Hours Min                               | 4/19/19  |   | ryland                               |
| death with the Maryland<br>ms 23a or 28a-f show<br>(must be notilited at   |                  | 10a. State 10b. County  |   | 10c. City, Town or Lo                                   | cation   |   |  |   | 10d. Inside City Limits              |
| Ba-f s   | cto              | MD Baltimo  | re  | Baltimon  | re   |   |  |   | 1 ☐ Yes 2 ☐No                        |
| with th  | Funeral Director | 10e. Street and Number  |   |   | 10f. Zip Code  |   | 10   | g. Citizen of What C                        | ountry?                              |
| eath y   | era              | 123 Lyndale Aven  | ue<br>12. Was Decedent E  | ever in II S 13 1                                       | 2123   |   | Consider Van er Ne                             | U.S.A.                                      | niana ladian                         |
| fter d   | F                | 1 Never Married 2 Married   | Armed Forces?   | 0   | If Yes, specify Cub  | an, Mexican, Pue                        | Specify Yes or No-<br>rto Rican, etc.)         | Black, Whi                                  | te, etc.                             |
| ING Z1Z13-UU36 be filed within 72 hours after death with the Marylar lat hygiene. d other then "natural", or itams 23s or 28s-f show event, the Maddeal Examiner must be neillist at | Completed by     | 3 X Widowed 4 □ Divorced  | If Yes, Give<br>Year or Dates:                                      |   | 1 ☐ Yes 2 🖾 No   | Specify:                                |  | Specify: W                                  | nite                                 |
| n 72 h   | lete             | 15. Decedent's Edi<br>(Specify only highest grad  |   | 16a. Deced  | dent's Usual Occup<br>kind of work done<br>DO NOT use retire | oation<br>during most of wo             | orking 1                                       | 6b. Kind of Business                        | /industry                            |
| within them  | dwo              | Elementary/Secondary (0-12)   | College (1-4or 5  | +)  | sewife   | u)                                      |  | Own Home                                    |                                      |
| a filed<br>other   | BeC              | 17. Father's Name (First, Middle, Last)   |   |   |  | 18. Mother's Na                         | me (First, Middle, M                           |   |                                      |
|  | To E             | John F. McGinnis  |   |   |  | Ann M                                   | eskill   |   |                                      |
| re, Maryle s 1 and 2 should t Health and Mer tiem 27 Is marks other traumatic  |                  | 19a. Informant's Name/Relationship (7   |   | 12  |  |   | ural Route Number,                             |   |                                      |
| teall and the the  |                  | Susan Owens/Daug  | nter  |   |  | Avenue B                                | altimore,                                      |   |                                      |
| DOT<br>Boss 1  |                  | 20a. Method of Disposition  1  Surial 2  Cremation 3  |   | I '   | natory or other pla  | 1                                       |  | 0c. Location - City or                      |                                      |
| Baltimore, permit. Pages 1 a Department of Hee Importent: If item eny injury or othe   |                  | 4 □ Donation 5 □ Other (Specify, 21. Signature of Funeral Service Licens                                    |   | Dulaney   | Valley  Name and Addre                                       |   |  | Timonium,                                   |                                      |
|  |                  | 100:11  |   | 2   |  |   | Miller-Di <sub>l</sub><br>Baltimore            | ppel Funer                                  | al Home Inc                          |
|  |                  | 23a. Part1. Enter the dise we, or composhock, or heart foliare. List only                                   | lications that caused   | the death. Do not ent                                   | er the mode of dyir  | ng, such as cardia                      | ic or respiratory arre                         | st,   | Approximate<br>Interval Between      |
| Physician  |                  | Immediate Cause (FiTTI disease or condition   | 0.  | SWOWIE  |  |   |  |   | Onset and Death                      |
| /Medical<br>Examiner   |                  | resulting in death)   |   | consequence of):  | 1  |   |  |   |                                      |
| xanimior   | <u></u>          | Sequentially list conditions,   | b. Due to (or as a  | consequence of):  |  |   |  |   |                                      |
| uted<br>I<br>Insit   | Examiner         | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | Due to (or as a   | consequence or,   |  |   |  |   |                                      |
| <b>6U,</b> be executed ciclen and burial-transi  | Exal             | that initiated events<br>resulting in death) Last   | C. Due to (or as a  | consequence of):  |  |   |  |   |                                      |
| - 6 X 6  | cal              | (   | d   |   |  |   |  |   |                                      |
| BOX BB/rt leath certificate to attending physic for use as the b   | Med              | IF FEMALE:  |   |   |  |   |  |   |                                      |
| BOX<br>lath cer<br>attendir<br>for use   | lan/             | 23b. Was decedent pregnant in the past 12 months?   | 23c. If yes, outcome of<br>1 ☐ Live birth                           | 2 Fetal death 3   | Ectopic pregnancy  | y                                       |  | 23d. Date of de<br>Month                    | livery<br>Day Year                   |
| GS, P.C. BOX DX uires that the death certifica signed by the attending phild be deteched for use as the  | Physiclan/Med    | 1 ☐ Yes 2 ♠No<br>9 ☐ Unknown  | 4☐ Pregnant at<br>9☐ Unknown  | time of death 5L  | Other (specify) _  |   |  |   | 23,                                  |
| F ta d as  | by Ph            | Part II. Other significant conditions co  | ntributing to death bu  | it not resulting in the u                               | nderlying cause giv  | ren in Part I.                          | 23e. Did toba                                  | acco use contribute t                       | o the cause of death?                |
| w requires that been signed be should be dete  | edb              |   |   |   |  |   | 1 🗌 Yes  | 2 □ No 3 □ P                                | robably 4 Unknown                    |
|  | Completed        |   |   |   |  |   | 24a. Was an                                    |   | utopsy findings available            |
| The<br>The<br>ate h  | E O              |   |   |   |  |   | autopsy<br>perform<br>1 Yes 2                  | ed? death?                                  | completion of cause of               |
| VITAI<br>icien: 1<br>sertificat<br>ector, p  | Be               | 25. Was case referred to medical examiner?  |   |   |  |   | ath  Check only one                            |   |                                      |
| Or VICA Physicien: this certific ral director,   | 2                | 1 Yes 2 No 27. Manner of Death  | Hospital:<br>1 ☐ Inpatier<br>28a. Date of Injur                     | nt 2 ER/Outpatier                                       |  | 4 Nursing                               | Home 5 Resider                                 |   | ocify)                               |
| Jing<br>Jing<br>After<br>fune  | Certification:   | 1 Natural 5 Pending 2 Accident investigation  | (Month, Day   | Year) 28b. Time of Injury                               | Wor  | yat<br>rk?<br>Yes 2 □ No                | 28d. Describe hov                              | v injury occurred                           |                                      |
| DIVISION  I or Attending after death.  Director: After in by the fune  | Ifica            | 3 Suicide 6 Could not be determined   | 286. Place of inju  | ry - At home, farm, str                                 |  |   | 28f. Location (Stre                            | et and Number or R                          | ural Route Number,                   |
| tal or rs afte el Dir  | Cert             | 4   Homicide  | building, etc   | . (Ѕресіту)   |  |   | City or Town,                                  | State)                                      |                                      |
| DIVISION To the Hospital or Attency within 24 hours after death To the Funeral Director:   | edical           | 29a. Certifier Check only one) Cartifying Phy   | rsician: To the best of<br>iner: On the basis of<br>and manner stat | f my knowledge, death<br>examination and/or in-<br>ted. | n occurred at the tir<br>vestigation, in my o                | me, date and plac<br>opinion, death occ | e, and due to the cau<br>urred at the time, da | use(s) and manner a<br>le and place, and du | s stated.<br>a to the cause(s)       |
| To th<br>within<br>To th<br>comp   | Me               | 29b. Signature and title of certifier   |   |   | 29c. Licens  | e number                                | 29   | d. Date signed (Mon                         | h, Day, Year)                        |
|  |                  | ) V. U.   | _   | WD  | D'   | 53462                                   |  | 12/21/0                                     | 5                                    |
| 3  |                  | 30. Name and address of person who c  |   | eath (Item 23a) (Type,                                  | Print)   | 200-1                                   | Slen Bur                                       | nie MA                                      | 21061                                |
| Sta  |                  | 31. Date filed (Month, Day, Year)   |   | r's Signature   | M.   | -014G                                   | DIEN MAIC                                      | ILC TAIL                                    | ~1061                                |
| Registr  | ar               | DEC 2 8 2005  | N. 9. 3. 5. 8. 1  | N. 15384  |  |   |  |   |                                      |

DHMH 17 Rev 1/2001

CURENS.

| 1 - For<br>State<br>Registra |
|------------------------------|
| 1. Decedent's                |
|                              |

State of Maryland / Department of Health and Mental Hygiene, O E Certificate of Death

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|----|----------|--------|---|
|    | Reg. No. | U      | U |

41844

| Physicis  | an             | Decedent's Name (First, Middle, La   | st)   |                              |  |   | 2. Date of Dea<br>Month  | th<br>Day Year                         | 3. Time of Death   |
|---|----------------|--|---|------------------------------|--|---|--|--|--|
| Physicia<br>/Medic  |                | CLAUDIA E  | VELYN PITTS   | 5                            |  |   | DEC.   | 24, 2005                               | 3:30P  |
| Examin  |                | 4a. Facility Name (If not institution, given                                       | e street and number)  |                              | 4b. City, Town, o                      | or Location of Dea                      | ith  | 4c. County of Deat                     |  |
|   |                | 4100 N. CHARL  | ES ST., APT.  | #1006                        | BALTI                                  | MORE C                                  | TTY  | N/A                                    |  |
| uneral  |                | 5. Social Security Number 6. S   | Sex 7. Age (In yrs.   |                              | If Under 1 Year<br>Months Days         | If Under 24 Hr                          |  |  | hplace (State or Fore untry)   |
| irector   |                | 226-42-4114  | □M 2X2F 96  | Yrs.                         | Months Days                            | HOUIS MI                                | s. 8. Date of Birth<br>(Month, Day<br>05/24/   | 1909 MAI                               | RYLAND   |
| -9-   |                | Usual Residence of Decedent  |   |                              |  |   |  |  | 1101   |
| how<br>E  |                | 10a. State 10b. County   | 10c. Cit  | y, Town or Lo                |  |   |  |  | 10d. Inside City Lim   |
| =   | ig             | MD N/A   |   | BALT                         | IMORE C                                | CITY                                    |  |  | 1X Yes 2□  |
| 128   | Director       | 10e. Street and Number   |   |                              | 10f. Zip Code                          |   | 1  | l0g. Citizen of What Co                | untry?   |
| 38 0  | <u>=</u>       | 4100 N. CHARLE   | S ST. APT #   | 1006                         | 212                                    | 18                                      |  | USA                                    |  |
| naturel; or iteme 23a or 28a-f ehow<br>dical Examiner must be rivitiled at                        | Funeral        | 11. Marital Status   | 12. Was Decedent Ever in U  | .S. 13.                      |  |   | Specify Yes or No-<br>into Rican, etc.)  | 14. Race - Ame                         |  |
| 은칅  | Ē              | 1 ☐ Never Married 2 ☐ Married  | Armed Forces? 1 ☐ Yes 2 🔯 No  | i                            |  |   | по нісал, есс.)  |  | etc.   |
|   | by             | 3 XWidowed 4 □ Divorced  | ff Yes, Give<br>Year or Dates:                                      |                              | 1 ☐ Yes 2 ☐XNo                         | Specify:                                |  | Specify: B1                            | LACK   |
| d other then Trature, or Home 23s of 28s-1 eno<br>event, the Medical Examiner must be invitted at | Completed      | 15. Decedent's E   |   |                              | dent's Usual Occup                     |   |  | 16b. Kind of Business/                 | Industry   |
| E E   | ple            | (Specify only highest gr<br>Elementary/Secondary (0-12)                            | College (1-4or 5+)  | life. l                      | kind of work done<br>DO NOT use retire | during most of w<br>d)                  | orking   | PUBLIC S                               | SCHOOL   |
| 2   | Eo             | 12TH   | 7 YEARS   | EDUC                         | ATOR/SC                                | HOOL TI                                 | EACHER   | SYSTEMS                                |  |
| ent,  | 0              | 17. Father's Name (First, Middle, Last   |   |                              |  |   | ame (First, Middle,  | Maiden Surname)                        |  |
| marked<br>matic ev  | To B           | JOHN ROSS B  | ARNUM   |                              |  | EVANO                                   | GELINE M   | ADORA HE                               | RROD   |
| E E   | -              | 19a. Informant's Name/Relationship   | Type, Prieth a nam dona   | 19b. Maifir                  | a Address (Street                      |   |  | r, City or Town, State, 2              |  |
| other traumatic   |                | WILLIAM H. PIT   | GRANDSON<br>TS TTT  |                              | -                                      |   |  | ANGELES,                               | 90043  |
| the   | -              | 20a. Method of Disposition   | 20b. F  | Place of Dispo               | sition (Name of                        |   |  | 20c. Location - City or                | Town, State  |
| 0.70  |                | 1 ☐ Burial 2 又Cremation 3 [  | Hemoval from State  | -                            | natory or other pla                    |   |  | TARRET .                               |  |
| eny injury or e   |                | 4 Donation 5 Other (Speci  |   |                              | REMATOR                                |   | 29/05  | CATONSVII                              | LE, MD   |
| eny in  |                | 21. Signature of Forneral Service Lice   | nsee X  | / 22                         | . Name and Addre                       | ess of Facility H                       | WELL FU  | NERAL HOM                              | E 21207  |
| 5 6 a   |                | 23a. Plat En r the discusse, or come stock, or heart failure. List only            | (1) 1) Ow   | 4                            | 4600 LI                                | BERTY I                                 | HEIGHTS  | AVE., BAI                              | TIMORE,  |
| ician<br>dical<br>niner   |                | disease or condition resulting in death)   | a. ADENE  |                              |  |   |  |  | 21 mon   |
|   | ner            | Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying | b. Due to (or as a conseq   | uence of):                   |  |   |  |  |  |
| attending physicien end<br>for use es the burial-transit  | Examiner       | cause. Enter Underlying Cause (Disease or injury that initiated events             | c   |                              |  |   |  |  |  |
| en e  |                | resulting in death) Last   | Due to (or as a conseq  | uence of):                   |  |   |  |  |  |
| ysici   | cai            |  | d   |                              |  |   |  |  |  |
| 0 5 th  | led            |  |   |                              |  |   |  |  |  |
| esn .   | iclan/Medicai  | fF FEMALE:<br>23b. Was decedent pregnant   | 23c. If yes, outcome of pregna<br>1 ☐ Live birth 2 ☐ Feta           |                              | Ectopic pregnanc                       | v                                       |  | 23d. Date of deli                      |  |
| o d for   | ICIE           | in the past 12 months?<br>1 ☐ Yes 2 ☐ No   | 4☐Pregnant at time of d   |                              | Other (specify)                        | ·7                                      |  | Month                                  | Day Year   |
| ache  | Physi          | 9 Unknown  | 9∐ Unknown  |                              |  |   |  |  |  |
| e det   | by P           | Part II. Other significant conditions  | contributing to death but not res                                   | ulting in the u              | nderlying cause gr                     | ven in Part I.                          | 23e. Did to  | bacco use contribute to                | the cause of death   |
| D D   |                |  |   |                              |  |   | 1 🗆 Y  | es 2⊅No 3□Pri                          | obably 4 Unkn  |
| 2 should be detached  | lete           |  |   |                              |  |   | 24a. Was a   | n 24b Were au                          | topsy findings availa  |
| 98 2  | Completed      |  |   |                              |  |   | autops   | sy prior to o<br>med? death?           | completion of cause  |
| ector, pag  |                | 26 Man one referred to made t  |   |                              |  |   | 1 Yes  | No 1 ☐ Yes                             | 2 No   |
|   | o Be           | 25. Was case referred to medical examiner?  1  Yes 2  No                           | Hospitaf:   | ICD/O                        | . all par   Ott                        |   | eath Check only or   |  |  |
| g in  | $\vdash$       | 1 Yes 2 No 27. Manner of Death   | 1 Inpatient 2   | ER/Outpatien<br>28b. Time of | 1 3 DOW                                | 4   Nursing                             |  | ence 6 Other (Spec                     | cify)  |
| funer   | tlon           | 1 ✓ Vatural 5 ☐ Pending  | 28a. Date of Injury<br>(Month, Day Year)                            | Infury                       | ₩o                                     | rk?<br>]Yes 2∐No                        |  |  |  |
| the f   | ca             | 3 Suicide 6 Could not b  | e 29a Place of Injury - At h  | ome farm ch                  |  | 2010                                    | 28f Location (S  | treet and Number or Ru                 | ral Poula Number   |
| d ri  | Certification: | 4 Homicide determined  | building, etc. (Specif  | y)                           | out, factory, office                   |   | City or Town   |  | rai moute mumber,  |
| completely filled in by the   |                | 29a Certifier Certifying P   | systems. To the horse of my limit                                   | material Street              | Lateral of the e                       | and the same and                        | A STATE OF THE STA | According to a control of              | efet - 1   |
| run   | dical          | (Check only 2 Medical Exa  | ny lifeian. To the best of my kno<br>niner: On the basis of examina | ition and/or in              | estigation, in my                      | me, cate and plac<br>opinion, death occ | curred at the time, d  | ate and place, and due                 | to the cause(s)  |
| To the Funarel Director: A<br>completely filled in by the fu                                      | Mec            | 29h Signature and title of certifier   | and manner stated.  | -                            | 29c. Licens                            | se number                               |  | !9d. Date <b>ş</b> îgned <i>[Montl</i> | Day Yearl  |
| = 8   |                | 96000111 Ve  | Lebart III MA   |                              | I _                                    | 3400                                    | -  | 12 /28/20                              | ) S  |
| , n   | l l            | J. Jewan Sy  |   |                              | טע                                     |   |  | 14/20/200                              | - Marie - Mari |
|   |                |  |   |                              |  |   |  |  |  |

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

DEC 2 8 2005 \ Magne

30. Name and address of pers in the completed cause of death (Item 23a) (Type, Print)

THEREU W. IGIENANT III NO 6301 N CHARLES ST MINMALE, NO 21212

|             |  |                | 1 - For<br>State<br>Registrar  | State of Maryla   |                            | rtment of Hea<br>tificate of De  |  | ntal Hygien                                       | CUUL  | 41845  |
|-------------|--|----------------|--|---|----------------------------|--|--|---|---|--|
| - 34        | Physici<br>/Medio  |                | 1. Decedent's Name (First, Middle, Last)  HMY  | PARI  | HAM                        |  | 2.   | Date of Death<br>Month                            | Day Year  | 3. Time of Death A                               |
|             | Examir   | er             | 4a. Facility Name (If not institution, give st 1239 N. BENTALO)  5. Social Security Number 6. Sex  | 1 STREET  | (0.4.5.1.5.1.)             | 4b. City, Town, or Loc<br>BALTIMOR<br>If Under 1 Year If                 | RE   |   | tc. County of Dea   | A  |
|             | Funeral:<br>Director   |                |  | 4 27 92   | rs. last birthday)<br>Yrs. |  | lours Min.   | Date of Birth<br>(Month, Day, Yea<br>Q · 24 · 19] | (r)   C(  | thplace (State or Foreign ountry)  VA            |
|             | ith the Marylan<br>or 28a-f show   | tor            | MD 10b. County   |   | City, Town or Lo           | _  |  |   |   | 10d. Inside City Limits 1   Yes 2  No            |
|             | th with the<br>23a or 28d  | al Director    | 10e. Street and Number 1239 N. BENTALO   |   |                            | 10f. Zip Code  |  | 10g. (  | Citizen of What Co  | ountry?  |
| 36          | permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: if item 27 is marked other than "naturel', or items 23a or 28a-f show myoriant: if item 27 is marked other than "naturel', or items 23a or 28a-f show hy jointry or other treumatic event, Ite Medical Examinar round by nutiliad at 2008. | by Funeral     | 11. Marital Status 1:<br>1 Never Married 2 Married   | 2. Was Decedent Ever in<br>Armed Forces?<br>1 ☐ Yes 2 <b>½</b> No<br>If Yes, Give             | If                         | Vas Decedent of Hispa<br>Yes, specify Cuban, M                           | nic Origin? (Specify<br>Mexican, Puerto Rica<br>Specify: | Yes or No-<br>an, etc.)                           | 14. Race - Ame<br>Black, Whit                                 | te, etc.   |
| 21215-0036  | in 72 hour<br>n "naturel<br>Apulical Ex  | Completed b    | 3 ☑ Widowed 4 ☐ Divorced  15. Decedent's Educ: (Specify only highest grade   | completed)  | 16a. Deced<br>(Give I      | ent's Usual Occupation<br>kind of work done during<br>O NOT use retired) | n<br>ng most of working                                  | 16b.  | Kind of Business  | LACK   |
|             | 2 should be filed within and Mental Hygiene. is marked other than eumatic event, the Ms  | Be Com         | Elementary/Secondary (0-12)  7   | College (1-4or 5+)  | _                          | ME MAKE  |  | irst, Middle, Maide                               | DOMES   | TIC  |
| Maryland    | 2 should be<br>and Mental<br>is marked o   | ToB            | FREDDIE SMITH  19a. Informant's Name/Relationship (Typ)  |   | 19b. Mailin                | Address (Street and  |  | UELLS   | or Town, State.   | Zin Code)  |
|             | es 1 and 2<br>of Health a<br>fitem 27 is<br>r other tre  |                | 20a. Method of Disposition   |   | ) 1239<br>Place of Dispos  | N. BENTA   |  | BALTO.  |   | 1216   |
| Baltimore,  | permit. Pages<br>Department of<br>Important: if it<br>any injury or o<br>ance.   |                | 1 ☑ Burial 2 ☐ Cremation 3 ☐ Re<br>4 ☐ Donation 5 ☐ Other (Specify)<br>21. Signature of Funeral Service Lice \s.   | L11   | TLE SHILL                  | atory or other place)  OH CEMETER  Name and Address of                   |  |   |   | VA   |
| Ba          | Departit. Departit. Imports eny inji   |                | 23a. Part1. Enter the disease, or complici   |   | VAU<br>5)5                 | Name and Address of IGHN C- GRE BALTO NAT                                | ENE FUNE<br>L'PIKE, B                                    | RAL SERVI<br>ALTO. MO                             | Œ<br>21229  | Approximate                                      |
|             | Physician<br>/Medical  |                | shock, or heart failure. List only one<br>Immediate Cause (Final<br>disease or condition<br>resulting in death)  | Due to (or as a dors)   | dra                        | tion   |  |   |   | Interval Between<br>Onset and Death              |
|             | Examiner   | er             | Sequentially list conditions, if any, leading to immediate   | Due to (or as a const   | equence of):               | tron   |  |   |   |  |
| oʻ.         | cate be executed<br>physicien and<br>the burial-fransit  | Examiner       | cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  | Due to (or as a consc   | equence of):               | e m  | elli   | Tu  | 7   |  |
| 68760,      | phy:   | ledicai        | € d.   | _ Chi   | rem                        | la   |  |   |   |  |
| P.O. Box    | The law requires thet the death certifica<br>tie hes been signed by the attending pt<br>page 2 should be detached for use as i   | Physician/Me   | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown   | c. If yes, outcome of preg<br>1 ☐ Live birth 2 ☐ Fe<br>4 ☐ Pregnant at time of<br>9 ☐ Unknown | etal death 3               | Ectopic pregnancy Other (specify)  |  |   | 23d. Date of del<br>Month                                     | livery<br>Day Year                               |
|             | n requires thet fhe de<br>been signed by the a<br>should be detached f   | ρ              | Part II. Other significant conditions conti  | ibiting to death but not re   | esulting in the un         | derlying cause given in  | Part I.  |   |   | o the cause of death?                            |
| al Records, |  | Completed      | - SYN  | cope<br>une   | To                         | THRIV  | /e   | 24a. Was an autopsy performed?                    | prior to death?   | utopsy findings available completion of cause of |
| of Vital    | 9 W =  | To Be          | 1 103 2  |   | ☐ ER/Outpatient            | 3□ DOA Other: 4  |  | 5 Sesidence                                       | 6 □Other (Spec  | cify)  |
| Division    | Jing<br>After<br>fune  | Certification: | 27. Manner of Death  FMatural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be  | 28a. Date of Injury<br>(Month, Day Year)  |                            |  | 2□No   | Describe how inj                                  |   |  |
| Div         | pital or A   |                | 4 Homicide determined  | 28e. Place of Injury - At building, etc. (Specials)   | cify)                      |  |  | City or Town, Sta                                 | fe)   | ural Route Number,                               |
|             | To the Hospital or Attent within 24 hours effer death To the Funerel Director: completely filled in by the   | Medicai        | (Check only one)  2 Medical Examine  29b. Signature and title of certifier   | r: On the basis of examinand manner stated.   | nation and/or invi         | estigation, in my opinio   | n, death occurred a                                      | it the time, date ar                              | c) and illumner as<br>nd place, and due<br>bate signed (Monti | e to the cause(s)                                |
|             | 1 3 + 5  |                | 30 Name and address of any   | Swort   | (au)                       | D31  | 1905   | 12  | -/23  | 185  |
| 1900        | )<br>Sta   | te.            | 30. Name and address of person who may all the state of t | pleted cause of death (It   | m)                         | 243/1  | MARYE  | HND   | AVE   | 2/219  |
|             | Registr  | - 6-4          | DEC 2 8 2005   | Bear to   | food                       | U  |  | : E5. E5.   |   |  |

| Medica   | וו  | . Decedent's Name (First, Middle, La   | 31/  | 10   | 165  |  | 2. Date of D<br>Month   | Day  | Year <b>2005</b>   | 3. Time of Dea   |
|--|---|--|--|--|--|--|---|--|--|--|
| viedica<br>kaminei   |   | a. Facility Name (If not institution, giv  | e street and number  | Peir   | 4b. City, Town, o  | r Location of D  | DECEM!  | 1  | County of Death  |  |
| mme  | -   | The Johns A  | PODKINS  | HOSDITAL   | BAL  | HIMOR  | E 1/4   |  |  |  |
| eral   |   | . Sociał Security Number 6. S  | Sex 7. A   | ge (In yrs. last birthday)   | If Under 1 Year<br>Months Days   | If Under 24 I  | Irs. 8. Date of 8   | irth <b>02/</b>  | 14/1935  | nplace (State or Fo  |
| tor  | _   | 3/0-48-/0/1  | IUM 2ŁIF   | 70 Yrs.  | World Duys   | 710013   | Feb.14  |  | D.C.   |  |
|  | -   | Jsual Residence of Decedent  10a. State 10b. County  |  | 10c. City, Town or Lo  | cation   |  |   |  |  | 10d. Inside City Li  |
| 3  | 5   |  | PG .   | Mitchelvil   |  | 1and   |   |  |  | 1 Yes 2  |
| Director   | 20  | 0e. Street and Number  |  |  | 10f. Zip Code  |  |   | 10g. Citiz   | en of What Co  | untry?   |
|  |   | FO/ P1 . 1 . 1 . D 1   |  |  | 20721  |  |   |  | USA  |  |
| 90   |   | 504 Burleigh Drix 1. Marital Status  | 12. Was Deceden<br>Armed Forces  | t Ever in U.S. 13, 1   |  | lispanic Origin  | (Specify Yes or N   | 10- 1  | 4. Race - Amer<br>Black, White   |  |
|  |   | 1 ☐ Never Married 2 Married  | 1 Yes 2 I  | INo  | Yes 2 No   | Specify:   | Jeno Hican, etc.)   |  |  |  |
| 1  | a by  | 3 Widowed 4 Divorced   | Year or Dates  |  | Λ  |  |   | 1  | Specify: B1a   |  |
| 9  | Completed   | 15. Decedent's E<br>(Specify only highest gra  |  | (Give  | dent's Usual Occup<br>kind of work done<br>DO NOT use retired  | during most of   | working   | 16b. Kir   | nd of Business/I   | ndustry  |
| 8  | E C   | Elementary/Secondary (0-12)  | College (1-4or   | Nurse  |  | 2)   |   | Se1f   | Employ   | ed   |
|  |   | 17. Father's Name (First, Middle, Last   |  | 110250   |  | 18. Mother's   | Name (First, Middle   |  |  |  |
| à  | 10 00   | Charles Lec  | - Willie   | Lee  |  | Rlandal  | e Cooper  | L  | 0.0  |  |
| The state of   | -  -  | 19a. Informant's Name/Relationship (   | Type, Print)   | 19b. Mailir  |  |  | Rural Route Num   |  |  | ip Code)   |
|  |   | William Prince (H  | Husband)   | 3504 E   | urleigh  | Dr.Mitc  | helville  | ,Md20  | 721  |  |
|  |   | 20a. Method of Disposition   | 30   | 20b. Place of Dispo  |  |  | Date  |  | cation - City or T   | Town, State  |
|  |   | XX Burial 2 Cremation 3 4 Donation 5 Other (Special  | JHemoval from State<br>(y)   | °Cheltenham  | Vet.Cem  | . 12/  | 21/2005   | Che1   | tenham,  | Mary1an  |
| - Suce   | I   | 21. Signature of Juneral Service Lice  | nsee   | . 22   | . Name and Addre   | ss of Facility   | ri-State  | Fune   | ral Ser  | vices  |
| ā  |   | Anny El  | inca   | $\mathcal{I}$ 57   | 32 Georg   | ia Aver  | ue NW Wa  | sh.D.  | C.20011  |  |
|  |   | <ol> <li>Part1. Enter the disease, or m<br/>shock, or heart failure. List only</li> </ol>  | plication that cause<br>one cause on each  | ed the death. Do not ent line.   | er the mode of dyir  | ng, such as car  | diac or respiratory   | arrest,  |  | Approximate<br>Interval Between  |
| an   |   | Immediate Cause (Final disease or condition  | META   | STATIC   | PANCRE   | ATTC   | CANCE   | FR   |  | Onset and Dea  |
| al<br>er   |   | resulting in death)  |  | s a consequence of):   |  |  |   |  |  |  |
| ₩.   |   | Sacualities at an action of any, leading to immediate cause. Enter Underlying Cause (Disease or injury   | b. Due to for a  | s a consequence of):   |  |  |   |  |  |  |
| 1  | uner  | rany, leading to immediate cause. Enter Underlying   | Due 10 (01 a   | s a consequence or.  |  |  |   |  |  |  |
| - Imen   | xar   | Cause (Disease or injury   |  |  |  |  |   |  |  |  |
|  |   | Cause (Disease or injury that initiated events resulting in death) Last  | c.<br>Due to (or a   | s a consequence of):   |  |  |   | _  |  |  |
| 100  | <u>a</u>  | that initiated events  |  | s a consequence of):   |  |  |   |  |  |  |
| 100  | ıcaı  | that initiated events  |  | s a consequence of):   |  |  |   |  |  |  |
| 100  | ıcaı  | that initiated events  | Due to (or a d   | e of pregnancy   |  |  |   | 2  | 3d. Date of delin  | very   |
| 10017  | ıcaı  | resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1 □ Yes 2 ▼No  | Due to (or a  d.  23c. If yes, outcom 1 Live birth 4 Pregnant  | e of pregnancy<br>2  Fetal death 3   | Ectopic pregnancy  | ,  |   | 2  | 3d. Date of deline   |  |
| 10017  | nysician/medical  | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   | Due to (or a  d.  23c. If yes, outcom 1  | e of pregnancy 2 Fetal death 3 at time of death 5  | Other (specify)  |  |   | 2  |  |  |
| Device of Manager  | Physician/Medical   | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown  | Due to (or a  d.  23c. If yes, outcom  1 Live birth  4 Pregnant  9 Unknown  contributing to death  | e of pregnancy 2 Fetal death 3 at time of death 5 but not resulting in the u   | Other (specify)  |  | -1  | tobacco u  | Month<br>se contribute to  | Day Yea  |
| Johnston Mandage   | Physician/Medical   | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2  No 9  Unknown   | Due to (or a  d.  23c. If yes, outcom 1  | e of pregnancy 2 Fetal death 3 at time of death 5 but not resulting in the u   | Other (specify)  |  | -1  |  | Month<br>se contribute to  | Day Yea  |
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| Della Madeland   | Physician/Medical   | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown  | Due to (or a  d.  23c. If yes, outcom  1 Live birth  4 Pregnant  9 Unknown  contributing to death  | e of pregnancy 2 Fetal death 3 at time of death 5 but not resulting in the u   | Other (specify)  |  | 24a. Wa   | tobacco us<br>Yes 2 [  | Month se contribute to No 3 Pro  | Day Yea the cause of deal obably 4 Unk   |
| leading the District Manager and Alexander   | Be Completed by Physician/Medical                           | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown  | Due to (or a d   | e of pregnancy 2 Fetal death 3 at time of death 5 but not resulting in the u   | Other (specify)  | en in Part I.  | 24a. Wa   | tobacco using the san opsy formed?   | Month se contribute to No 3 Pro  24b. Were au prior to death?  | the cause of deal obably 4 Unknown topsy findings available or cause of the cause o |
| To Do O complete the Development of the Angelon  | to be completed by Physician/Medical                        | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   | Due to (or a d.  23c. If yes, outcom 1 Live birth 4 Pregnant 9 Unknown contributing to death   | e of pregnancy 2 Fetal death 3 at time of death 5 but not resulting in the u   | Other (specify)  | 26. Place of   | 24a. We autoper 1 per 1 | tobacco using tobacco using the same opsy formed?  | Month se contribute to No 3 Pro 24b. Were au prior to c death? 1 Yes   | the cause of deat obably 4 Munking topsy findings available of caus  |
| To Do O complete the Development of the Angelon  | to be completed by Physician/Medical                        | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   | Due to (or a  d.  23c. If yes, outcom  1 Live birth  4 Pregnant  9 Unknown  contributing to death  Linpa  28a. Date of In  (Month, D   | e of pregnancy 2 Fetal death 3 at time of death 5 but not resulting in the uncertainty and time to the control of the control  | Other (specify)  nderlying cause give  st 3 □ DOA Other  28c. Injur Wor  | 26. Place of ler: 4 \( \text{Nursin} \) \( \text{v} \) | 24a. Wa<br>autroper<br>1 Yes  | tobacco using tobacco using the same opsy formed?  | Month se contribute to No 3 Pro 24b. Were au prior to c death? 1 Yes   | the cause of death obably 4 Munkritopsy findings available 2 Market 2 Marke |
| To Do O complete the Development of the Angelon  | to be completed by Physician/Medical                        | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown  Part II. Other significant conditions examiner? 1  Yes 2 No 27. Manner of Death Natural 5 Pending investigations of Could not the condition of the conditions of the could not the conditions of the could not the conditions of the could not t | Due to (or a  d.  23c. If yes, outcom 1  | e of pregnancy 2 Fetal death 3 at time of death 5 but not resulting in the understanding in t | Other (specify)  Inderlying cause give  Inder | 26. Place of   | 24a. Wa authority per 1 Yes Death Check on 19 Home 5 Res 28d. Describe  | tobacco uside to | Month se contribute to No 3 Pro  24b. Were aui prior to death? 1 Yes  G Other (Spector occurred)   | the cause of death obably 4 Munkr topsy findings avaiompletion of cause 2 Munkr  |
| To Do O complete the Development of the Angelon  | to be completed by Physician/Medical                        | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   | Due to (or a  d.  23c. If yes, outcom    Live birth    Pregnant  9 Unknown  contributing to death    Hospital: 1 Minpai  28a. Date of In  (Month, D  | e of pregnancy 2 Fetal death 3 at time of death 5 but not resulting in the uncertainty tient 2 EP/Outpatier jury 28b. Time of  | Other (specify)  Inderlying cause give  Inder | 26. Place of ler: 4 \( \text{Nursin} \) \( \text{v} \) | 24a. Wa auto auto print 1 Yes  Death **Check only 19 Home 5   Res 28d. Describe  28f. Location  | tobacco uside to | Month  se contribute to  No 3   Pro  24b. Were au prior to c death? 1   Yes  6   Other (Spec   | the cause of death obably 4 AUnkr topsy findings avaitompletion of cause 2 AU to   |
| leading Manieland Complete Manieland   | Certification; 10 be completed by Physician/Medical         | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   | Due to (or a  d.  23c. If yes, outcom 1 Live birth 4 Pregnant 9 Unknown contributing to death  Hospital: 1 Inpa  28a. Date of In (Month, D   | e of pregnancy 2 Fetal death 3 at time of death 5 but not resulting in the use tient 2 ER/Outpatier jury 28b. Time of Injury nijury - At home, farm, street. (Specify)   | other (specify)  Inderlying cause give  at 3 □ DOA Other  28c. Injury  Wor  M 1 □  eet, factory, office  | 26. Place of lef: 4 Nursin Yat k? Yes 2 No             | 24a. Wa pur pur pur pur pur pur pur pur pur pur   | s an oppsy formed? 22 No one sidence 6 how injury (Street andown, State)   | Month  se contribute to  No 3 Pro  24b. Were au prior to c death? 1 Yes  GOther (Spec  | the cause of death babby 4 Munkr topsy findings avaiompletion of causi 2 Moo   |
| Annual Continued on To Do Opening by Obered Ships (Mandleson)  | legical Certification; 10 be Completed by Physician/Medical | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   | Due to (or a  d.  23c. If yes, outcom 1 Live birth 4 Pregnant 9 Unknown contributing to death  Hospital: 1 Inpa  28a. Date of In (Month, D   | e of pregnancy 2 Fetal death 3 at time of death 5 but not resulting in the u but not resulting in the  | other (specify)  Inderlying cause give  at 3 □ DOA Other  28c. Injury  Wor  M 1 □  eet, factory, office  | 26. Place of ler: 4 Nursin y at k? Yes 2 No            | 24a. Wa pur pur pur pur pur pur pur pur pur pur   | s an oppy formed? 2 No one sidence 6 how injury (Street and own, State) e cause(s) e, date and   | Month  se contribute to  No 3 Pro  24b. Were au prior to c death? 1 Yes  GOther (Spec  | the cause of death obably 4 Munkr topsy findings available of cause 2 March 1997 (1997)  Tal Route Number, stated, to the cause(s)   |
| of the Manual Control of the Control | legical Certification; 10 be Completed by Physician/Medical | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   | Due to (or a  d.  23c. If yes, outcom    Dive birth    Pregnant    Unknown    Contributing to death    Contributing to death | e of pregnancy 2 Fetal death 3 at time of death 5 but not resulting in the u but not resulting in the  | other (specify)  onderlying cause give  onderlying cause give  at 3 □ DOA  other  28c. Injury  working the time of time of time of the time of time of the time of tim | 26. Place of ler: 4 Nursin y at k? Yes 2 No            | 24a. Wa pur pur pur pur pur pur pur pur pur pur   | s an oppy formed? 2 No one) sidence 6 how injury (Street annown, State) c cause(s) b, date and   | Month  se contribute to  No 3 Pro  24b. Were au prior to c death? 1 Yes  GOther (Spec r occurred  d Number or Ru  and manner as place, and due | the cause of death obably 4 Munkr topsy findings available of cause 2 March 1997 (1997)  Tal Route Number, stated, to the cause(s)   |

Johanna Baltimore, Maryland 21215-0036 Ferdelamper

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2 Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Physician December JOHANNA PAULA PFERDEKAMPER 20 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Himore ranklin Square 105 D da Year If Under 24 8. Date of Birth (Month, Day, Year) Feb. 18, 1913 Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min GERMANY 1 □ M 2 🖸 F 92 Yrs 216~52~7076 Director Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d, Inside City Limits r than "natural", or items 23s or 28s-f ehow the Medical Examiner must be notified at Baltimore County 1 Yes 2000 Baltimore Maryland Direct 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21236 **USA** 4738 Ridae Rd. 12. Was Deceden! Ever in U.S. Armed Forces? 1 ☐ Yes XX☐ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status X1X Never Married 2 Married Specify: White 1 ☐ Yes XX No Specify: δ 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) 8 yrs. permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: if item 27 is marked other than any injury or other traumatic event, ITAM any place. Seifert's Florist Florist 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Carolina Pflantz Gustav Pferdekamper 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4743 Ridge Rd. Baltimore, Md. 21236 Elsie W. Seifert (Niece) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Slate X⊠ Burial 2 ☐ Cremation 3 ☐ Removal from State Gardens of Faith Cem. 12~27~05 Baltimore, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Lassann Funeral Home 74Ul Belair Rd. Baltimore, Md. 21236 23a m.1. Enter the disease, or complet lions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to min adiata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760, Completed by Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes No 2 Fetal death 3 Ectopic pregnancy Day 4☐Pregnant at time of death 5 Other (specify) o 9 Unknown 9 Unknow Division of Vital Records, P. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 M No 3 Probably 4 Unknown 1 Yes 24a. Was an autopsy performed?
1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? 2 No 1 Yes 25. Was case referred to medical examiner? Certification: To Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3□ DOA After this funeral of 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 Pending death. neral Director: A 1 Tes 2 No investigation 2 Accident 3 🗌 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 | Homicide within 24 hours after To the Funeral Dire Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D3056296 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Square Drive, Baltimore, MD. 21237 9000 Fran/6/1

DHMH 17 Rev 1/2001

State Registrar

31. Date filed (Month, Day, Year)

32. Registrar's Signature

|                     |  |                | For  | State of M                                     |   |             |                                     | lealth and                               | •                                   |  | _egible.                   |  |
|---------------------|--|----------------|--|--|---|-------------|-------------------------------------|--|-------------------------------------|--|----------------------------|--|
|                     |  |                | 1 - State<br>Registrar   |  |   | Certi       | ficate of                           | Death                                    |                                     | Reg. No.                               | 005                        | 41848  |
|                     | Physici<br>/Medi   |                | 1. Decedent's Name (First, Middle, Barbara Johnn Pae   |  |   |             |                                     |  | 2. Date of D<br>Month<br>DECE M     | Day                                    | Year 4 2005                | 3. Time of Death                                 |
|                     | Examir   |                | 4a. Facility Name (If not institution, o   | nive street and number                         | 2                                       | 4           | b. City, Town, o                    | r Location of Deal                       |                                     |  | County of Dea              |  |
|                     |  |                | LORIEN (Q).  | RIVERSIJ                                       | ) <i>E</i>                              |             | BEL                                 | TAMO                                     |                                     | 1                                      | TARFO                      | e D  |
|                     | Funeral  |                |  | . Sex 7. A<br>1 □ M 2 1 F                      | ge (In yrs. last bii                    |             | If Under 1 Year<br>Months Days      | If Under 24 Hrs<br>Hours Min.            | (Month, D                           | Pav. Year)                             | 9. Bir<br>C                | rthplace (State or Foreign                       |
|                     | Director   |                | 227-44-7455 Usual Residence of Decedent  | 7.   | 71                                      | 113.        |                                     |  | 10/26/                              | 1934                                   | Vir                        | ginia  |
|                     | show   |                | 10a. State 10b. County   |  | 10c. City, Tow                          | m or Loca   | tion                                |  |                                     |  |                            | 10d. Inside City Limits                          |
|                     | the Maryla<br>28a-1 shor   | į              | MD Harford   | 1  | Aberdo                                  | oon         |                                     |  |                                     |  |                            | 1 X Yes 2 □ No                                   |
|                     | with the Maryland<br>a or 28a-f show<br>Le notified at   | Director       | 10e. Street and Number   | -  |   |             | 10f. Zip Code                       |  |                                     | 10g. Citiz                             | en of What C               | ountry?  |
|                     | € 23   |                | 51 Swan Street   |  |   |             | 21001                               |  |                                     | USA                                    |                            |  |
|                     | items 23   | Funerai        | 11. Marital Status   | 12. Was Decedent<br>Armed Forces               | ?                                       | 13. Wa      | s Decedent of H<br>es, specify Cuba | lispanic Origin? (S<br>an, Mexican, Puer | Specify Yes or N<br>to Rican, etc.) | 10- 1                                  | 4. Race - Am<br>Black, Whi | erican Indian,<br>te. etc.                       |
| Maryland 21215-0036 | 72 hours after<br>natural', or ite<br>dical Examine  | by             | 1 Never Married 2 Married 3 Widowed 4 Divorced   | 1 ☐ Yes 2 ☐<br>If Yes, Give<br>Year or Dates:  | (No                                     |             | Yes 2X No                           | Specify:                                 |                                     |  |                            | hite   |
| 5-0                 | 72   | etec           | 15. Decedent's<br>(Specify only highest of   | Education<br>grade completed)                  | 16a.                                    | Deceder     | it's Usual Occup                    | ation<br>during most of wo<br>d)         | rking                               | 16b. Kin                               | d of Business              | /Industry  |
| 121                 | within ene.  | Completed      | Elementary/Secondary (0-12)<br>10th  | College (1-4or                                 |   |             |                                     |  |                                     |  |                            |  |
| d<br>2              | be filed<br>stal Hygie<br>of other   |                | 17. Father's Name (First, Middle, La   | st)  | DA                                      | cerar       | y Techn                             | CCAN 18. Mother's Na                     | ma /First Middl                     |  |                            | aseteria_  |
| an                  | o d a o  | To Be          | Horace Roosevelt   |  |   |             |                                     |  |                                     |  |                            |  |
| Z Z                 | 2 shoul<br>and Mi<br>is marl<br>aumati   | Ě              | 19a. Informant's Name/Relationship   |  | 196                                     | . Mailing   | Address (Street                     | Inas Em                                  |                                     |  |                            | Zip Code)  |
|                     | 2 = 2 = z  |                | Kimberly Pack- Do  | ughter   |   |             |                                     | t, Aberd                                 |                                     |  |                            |  |
| ē,                  |  |                | 20a. Method of Disposition   |  | 20b. Place of                           | f Dispositi | on (Name of<br>ory or other place   |  | Date                                |  | ation - City or            | Town, State                                      |
| Ē                   | თ ≃ :: •   |                | 1 ☐ Burial 2 🂢 Cremation 3  1 ☐ Donation 5 ☐ Other (Spe  | ☐Removal from State<br>cify)                   | •                                       | -           | s & Co.                             | 1  | 9/05                                | West                                   | Chest                      | оп РД  |
| Baltimore,          | permit. Pa<br>Departmer<br>Important<br>any injury   | 1              | 21. Signature of Funeral Service Lic   | censee   |   | 22. N       | ame and Addre                       | ss of Facility                           |                                     | T. D.                                  | 1                          | ot, in   |
| _                   | 90 = 90  | 1.1            | Julaine m  | m. Dim   | HO                                      | 123         | S. Wash                             | ss of Facility<br>nith Fund<br>ungton,   | Havre of                            | le Gro                                 | ice. MI                    | 21078  |
|                     |  |                | 20a Part 1. Enter the disease, or co<br>shock, or heart failure. List on                                 | mplications that cause<br>ly one cause on each | d the death. Do                         | not enter   | he mode of dyin                     | ng, such as cardia                       | or respiratory                      | arrest,                                |                            | Approximate<br>Interval Between                  |
|                     | Physician  |                | Immediate Cause (Final disease or condition resulting in death)  | _ a  | emer                                    | 1+1         | <u>a</u>                            |  |                                     |  |                            | Onset and Death                                  |
|                     | /Medical<br>Examiner   |                | resulting in dealth)   | Due to (or as                                  | s a consequence                         | of):        |                                     |  |                                     |  |                            | Tero y   |
|                     |  | F              | Sequentially list conditions,  | b. Due to (or as                               | s a consequence                         | of):        |                                     |  |                                     |  |                            |  |
|                     | uted<br>1<br>Insit   | nin.           | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events |  | ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, |             |                                     |  |                                     |  |                            |  |
| Ć,                  | be executed<br>sician and<br>burial-transit  | Examiner       | resulting in death) Last   | Due to (or as                                  | a consequence                           | of):        |                                     |  |                                     |  |                            |  |
| 760,                | w - 0  | cai            |  | d  |   |             |                                     |  |                                     |  |                            |  |
| 89                  | certificat<br>nding phy<br>use as th   | Medi           | (F.FELLUS  |  |   |             |                                     |  |                                     |  |                            |  |
| Вох                 | ith ce<br>tendii<br>or use   | Physician/M    | IF FEMALE:<br>23b. Was decedent pregn  | 23c. If yes, outcome<br>1 ☐ Live birth         | e of pregnancy<br>2 Fetal death         | 3 □E        | topic pregnancy                     | ,  |                                     | 23                                     | 3d. Date of de             | •  |
|                     | 0 0  | sici           | in the past 12 months?<br>1 ☐ Yes 2 ☐ No<br>9 ☐ Unknown  | 4□Pregnant a<br>9□Unknown                      | at time of death                        |             | ther (specify)                      |  |                                     |  | Month                      | Day Year   |
| P.0                 | ac by  |                | Part II. Other significant conditions  | contribution to death                          | but not reculting it                    | n the unde  | shina anuan anu                     | an in Book I                             | 220 Did                             | ************************************** |                            | the cause of death?                              |
| ds,                 | se uni   | l by           |  | mor  |   | . CO        | ( ) Cause giv                       | on at rait t.                            |                                     | Yes 2                                  |                            | robably 4 Unknown                                |
| Š                   | w requir<br>been s<br>should   | Completed by   | - Di Will  | T NO F   | ( exc                                   | 150         | <del>0-)</del>                      |  | 1                                   |  |                            |  |
| Rec                 | e lav<br>has<br>je 2   | m              |  |  |   |             |                                     |  | 24a. Wa<br>auto                     | s an<br>opsy<br>ormed?                 | 24b. Were at<br>prior to   | utopsy findings available completion of cause of |
| Vital Records,      | (0)  | e Co           | 25 Was asso referred to modical  |  |   |             |                                     |  | 1 ☐ Yes                             | 28 No                                  | 1 ☐ Yes                    | 2 □ No   |
| Ξ                   |  | o Be           | 25. Was case referred to medical examiner?   | Hospital:                                      | ient 2 ER/Ou                            | strationt   | 3□ DOA Oth                          | 26. Place of Dea                         |                                     |  |                            | 7. )   |
| o                   |  | -              | 27. Manner of Death  | 28a. Date of Inj                               | ury 28b.                                | Time of     | 28c. Injur                          | y at                                     | lome 5 Res                          |  |                            | cify)  |
| ion                 | Attending I<br>r death.<br>ector: After<br>by the funer  | atio           | 1 Natural 5 ☐ Pending<br>2 ☐ Accident investigat   | (Month, Di                                     | ay rear) (                              | njury       | M 1                                 | k?<br>Yes 2 □ No                         |                                     |  |                            |  |
| Division            | r Atte<br>er de<br>recto<br>by th  | Certification: | 3 ☐ Suicide 6 ☐ Could not<br>4 ☐ Homicide determine  | ad 28e. Place of in                            | jury - At home, fa                      | ırm, street | , factory, office                   |  | 28f. Location                       | (Street and<br>own, State)             | Number or R                | ural Route Number,                               |
|                     | ital o<br>irs aff<br>ral Di<br>led in  |                |  |  |   |             |                                     |  |                                     |  |                            |  |
|                     | To the Hospital or Attent within 24 hours after death To the Funeral Director; completely filled in by the | edical         | Check only 2 Medicel Ex  | Physician: To the best<br>aminer: On the basis | of examination an                       | e, death o  | curred at the tin                   | ne, date and place<br>pinion, death occu | e, and due to the                   | cause(s) a                             | ind manner as              | s stated.  |
|                     | thin 2<br>the<br>mplet   | Med            | one) 29b. Signature and title of pertifier   | and manner s                                   | tated.                                  |             | 29c. License                        |  |                                     |  | signed (Mont               |  |
|                     | 5 7 × 5  |                |  | h  | 2                                       |             | Luc. Liceris                        | OFCE                                     | 2                                   | Dale                                   | Signed (Mont               |  |
|                     |  |                |  | ~  |   |             |                                     | 1758                                     |                                     | THE C                                  | embei                      | 15,200   |

State Registrar

31. Date filed (Month, Day, Year)
DEC 2 8 2005

|      |                 |  | 1                             | For State of Maryland / State Registrer  | Department of Health and Men<br>Certificate of Death  | tal Hygiene                                   |   | 1849  |
|------|-----------------|--|-------------------------------|--|---|---|---|---|
|      |                 | Physicia   | ลก                            | 1. Decedent's Name (First, Middle, Last) Nora Emeline Pippin   | 11  | Date of Death Month Da  2000 December         | 17 2005                                     | 3. Time of Death                              |
|      |                 | /Medic<br>Examin   |                               | La. Facility Name (If not institution, give street and number)   | 4b. City, Town, or Location of Death  | 40  | C. County of Death                          | d   |
|      |                 | Funeral<br>Director  |                               | 5. Social Security Number  6. Sex 1 □ M 2 🕱 F  7. Age (In yrs. last b.   | irthday) If Under 1 Year If Under 24 Hrs. 8. r<br>Months Days Hours Min. 0  | Date of Birth<br>Month, Day, Year<br>8/31/192 | 9. Birthp<br>Court<br>Vira                  | lace (State or Foreign<br>try)<br>LNLA        |
|      |                 |  | - h                           | Usual Residence of Decedent  | wn or Location  |   |   | 0d. Inside City Limits                        |
|      |                 | the Mary<br>28a-f sh   | ector                         | MD Harford Havre   | de Grace  | 10g. C  | itizen of What Cour                         | 1 X Yes 2 □ No                                |
|      |                 | 23a or   | ral Dir                       | 1429 Chapel Road   | 21078   | us  | A<br>14. Race - Americ                      | an Indian                                     |
|      | 36              | 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hyglene. Health and Mental Hyglene. John 27 is merked other than "neturel", or items 23a or 28a-f show ten 27 is merked other than "neturel", or items 23a or 28a-f show ther traumatic event, if the Modical Examiner "ust be notified at | Completed by Funeral Director | 11. Marital Status  1 □ Never Married 2 ☑ Married  12. Was Decedent Ever in U.S. Armed Forces?  1 □ Yes 2 ☑ No If Yes, Give  | 13. Was Decedent of Hispanic Origin? (Specify If Yes, specify Cuban, Mexican, Puerto Rica 1 ☐ Yes 2 ☒ No Specify: | res or No-<br>in, etc.)                       | Black, White,                               | etc.  |
|      | 21215-0036      | 72 hours<br>"neturel",<br>dical Ex.  | eted b                        | 3 ☐ Widowed 4 ☐ Divorced Year or Dates:  15. Decedent's Education (Specify only highest grade completed)  16.  | a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)           | 16b. I  | Kind of Business/In                         |   |
|      | 2121            | ed within<br>ygjene.<br>er than<br>t, Ire Me   | Comp                          | occitio, bo con  | Seamstress  |   | l6-Employ                                   | 1ed   |
|      | Maryland        | uld be fill<br>fental Hy<br>rked oth<br>tic even   | To Be                         | 17. Father's Name (First, Middle, Last)  Charles Franklin McCroskey  | 18. Mother's Name (Fil<br>Bessie Bel  | l Fleeno                                      | ケ   |   |
|      | Mary            | nd 2 shouth and N  | •                             | 1 0 1 1  | Db. Mailing Address (Street and Number or Rural Ro<br>811 Bernadette Ct., For                                     |   |   |   |
|      | Jore,           | ages 1 au<br>nt of Hea<br>t: If item   |                               | 20a. Method of Disposition  1 □ Burial 2 □ Cremation 3 🛛 Removal from State  | of Disposition (Name of Pate ery, crematory or other place)   |   | Location - City or To                       |   |
|      | Baltimore,      | permit. Pages 1 and 2 should be Department of Health and Menta Importent: If item 27 is marked eny injury or other traumatic ev 200.2.   |                               | . 4 □ Donation 5 □ Other (Specify) Mt. V 21. Signature of Funeral Service Licensee   | Mid Choll-Smith Funera  | l Home.                                       | P.A.  |   |
|      |                 | 45500  | 4                             | 28a. Part1. Enter the disease, or complications that caused the death. Do shock, or heart failure. List only one cause on ach line.  | 123 S. Washington, Hav<br>o not enter the mode of dying, such as cardiac or re                                    | spiratory arrest,                             | lace, mo                                    | Approximate Interval Between Onset and Death  |
|      |                 | Pnysician<br>/Medical  |                               | Immediate Cause (Final disease or condition resulting in death)  a   | e of):  |   |   |   |
|      |                 | Examiner   | er                            | Sequentially list conditions, if any, leading to intringulate cause. Enter Underlying Cause (Disease or injury   | BILLIKION   |   |   |   |
|      |                 | be executed<br>sician and<br>burial-transit  | Examiner                      | cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last  | n í ) //<br>e of):  |   |   |   |
|      | 8760            | icate be ex<br>physician<br>s the buria  |                               | d. Latter AW   | Myay Nisonso  |   |   |   |
|      | P.O. Box 68760, | The law requires that the death certificate be executed the has been signed by the attending physician and page 2 should be detached for use as the burial-transit   | Physician/Medical             | IF FEMALE: 23b. Was decedent pregnant in the past 12 morths? 1   Yes   2   No   9   Unknown   23c. If yes, outcome of pregnancy   1   Live birth   2   Fetal dea   4   Pregnant at time of death   9   Unknown   9 |   |   | 23d. Date of deliv<br>Month                 | ery<br>Day Year                               |
|      |                 | v requires that the deben signed by the should be detached   | by                            | Part II. Other significant conditions contributing to death but not resulting  | ; in the underlying cause given in Part I.  |   | o use c≥ tribute to t                       | he cause of death?                            |
| Jora | Records,        | The law requ<br>te has been<br>age 2 should  | Completed                     | Chance arm Freduce   |   | 24a. Was an autopsy performed 1 Yes 2 2 1     | prior to co<br>death?                       | opsy findings available impletion of cause of |
| 1    | Vital           | Physicien:<br>rthis certifica<br>ral director, p   | o Be C                        | 25. Was case referred to medical examiner?  1 \( \text{Yes} \) 2 \( \text{PNo} \)  Hospital: 1 \( \text{Inpatient} \) 2 \( \text{EPN} \)   | 26. Place of Death (C<br>Outpatient 3 □ DOA Other: 4 Nursing Home   | T-21/11/12                                    | 6 □Other (Speci                             | fy)   |
| 5    | on of           | ding Phy<br>h.<br>After this<br>funeral c  | <u> -</u>                     |  | o. Time of lnjury at 28d Work?  M 1 □ Yes 2 □ No  | f. Describe how in                            | jury occurred                               |   |
| de   | Division        | or Attending<br>after death.<br>Director: After<br>Jin by the fune   | Certification:                | 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, building, etc. (Specify)   | farm, street, factory, office 28f.  | . Location (Street and City or Town, Sta      | and Number or Rur<br>ate)                   | al Route Number,                              |
| 3    | _               | Hospite<br>Hours<br>Funerel  | ledical Ce                    | 29a. Certifier (Check only one)  1  Certifying Physician: To the best of my knowled 2  Medicel Examiner: On the basis of examination and manner stated.  | Ige, death occurred at the time, date and place, and and/or investigation, in my opinion, death occurred          | I due to the cause<br>at the time, date a     | (s) and manner as s<br>and place, and due t | stated.<br>o the cause(s)                     |
|      |                 | To the within 2 To the comple  | Med                           | 29b. Signature and title of certifier  | 29c. License number   | 29d. E  | Date signed (Month,                         | Day, Year)                                    |
|      | l               | )  |                               | 30. Name and address of person who completed cause of death (Item 23.  | a) (Type, Print) W/2 Mb6  | mn 2  | 1078  |   |
|      |                 | St<br>Regis  | ate<br>trar                   | 31. Date filed (Month, Day, Year) DEC 2 8 2005   | Specie  |   |   |   |

| Projection   Pro   |          |   |        | 1 - For Amend Item   | State of Mary 18850                      | P <b>2/28/05</b> The He<br>Certificate of D                      | ealth and Me<br>Death                      |  | ene<br>. No. 0 0 5                         | 41850   |
|--|----------|---|--------|--|--|--|--|--|--|---|
| POPULATION TO USE A COUNTY OF THE POPULATION OF CHAIN THE SOUTH OF THE POPULATION OF THE POPULATION OF THE POPULATION OF THE POPULATION OF THE POPULATION OF THE POPULATION OF THE POPULATION OF THE |          | Physici   | an     |  |  | Diel la  |  | Month                                    |  | 7   |
| DOUBLETON TO STORY PARTY |          | /Media  | al     |  | reet and number)                         |  |  | December                                 |  | 7067 M  |
| Discourse of Proposed Support Control  |          | Exami   | er     | The Johns Ho   | 11: 0 - 11: 0'l                          | A 11/1   |  | ity                                      | 40. Obuity of Death                        | 11/4  |
| 100, Carry   100   |          |   |        | /V//Y 101  | 7, Age (In yrs. last                     | birthday) If Under 1 Year Months Days                            | If Under 24 Hrs.                           | (Month, Day, Y                           | ear) (Cou                                  | ntoy) ,   |
| The service of the control of the co |          | land ow   |        |  | 10c. City, To                            | own or Location  | •  |  |  | 10d. tnside City Limits                         |
| The service of the control of the co |          | Ba-feh  | ctor   | Nd Baltin  | rore Wi                                  | ndsor Mi   | ill  |  |  | 1 □ Yes 2 No                                    |
| The service of the control of the co |          | with th   | Dire   | 10e. Street and Number   | not amount                               | 10f. Zip Code  | oud  | 10g                                      | . Citizen of What Cou                      | ntry?   |
| 19. Mailing Address (Sinea and Number or Pipe) (Pipe) (Pip |          | deeth   | nera   | 11. Marital Status   | . Was Decedent Ever in U.S.              | 13. Was Decedent of Hisp   | panic Origin? (Spec                        | rify Yes or No-                          |  |   |
| 19. Mailing Address (Sinea and Number or Pipe) (Pipe) (Pip | 9000     | nours efter<br>ural; or ite                         | þ      | /  | 1 ☐ Yes 2 No<br>If Yes, Give             |  |  | acan, etc.)                              | Specify: A+                                | RICAN   |
| 19. Mailing Address (Sinea and Number or Pipe) (Pipe) (Pip | 15       | in 72 l   | ojete  | (Specify only highest grade  | completed)                               | (Give kind of work done dui                                      | on<br>ring most of working                 | g N/A 16                                 | b. Kind of Business/In                     | dustry N/A                                      |
| 19. Mailing Address (Sinea and Number or Pipe) (Pipe) (Pip |          | od with   | Com    | Etementary/Secondary (0-12)  | Cotlege (1-4or 5+)                       |  |  |  |  |   |
| 20. May of Disposition (Plane of Disposition) | and      | oth oth   | Be     | 17. Father's Name (First, Middle, Last)  | shaedani                                 | 1.   | 8. Mother's Name (                         | (First, Middle Ma                        | Wheeler                                    |   |
| 20. May of Disposition (Plane of Disposition) | ary      | should<br>and Me<br>a mark<br>umatic                | ī      | 19a, Informant's Name/Relationship (Type   |  | 9b. Mailing Address (Street and                                  | d Number or Ryrai                          | Route Number, C                          | ity or Town, State, Zip                    | Code)   |
| A Donation of Dona | -        | and 2<br>Beith a<br>n 27 is                         |        | Keith Richar   | dson/Father =                            | 3 Farmino  | 1 . //                                     | ourt le                                  | 1 1  | in all  |
| Privision (Accided Examiner)  Privis | ore      | if iter<br>or oth                                   |        | 1X Burial 2 ☐ Cremation 3 ☐ Re   | noval from State                         | tery, crematory or other place)                                  |  | 1 0                                      | c. Location - City or To                   | own, State                                      |
| Privision (Accided Examiner)  Privis | Ħ        | artmer<br>ortant:<br>injury                         |        |  |  |  |  | 1  | indallsto                                  | wn,MD   |
| Physician Medical Examiner    Physician Medical Examiner   Physician   Physician Medical Examiner   Physician   Physician   Physician Medical Examiner   Physician   Physician   Physician Medical Examiner   Physician   Phy | Ba       | Den<br>imp  |        | Manshall   | Malle                                    | 9200Libe   | rt-Pm                                      | 1 Pand                                   | 111  | MD21122   |
| Physician (Thedicial Examiner)  The proper of the properties of th |          |   |        | 23a. Ranti, Enter the disease, or complications shock, or heart failure. List only one | tions that caused the death. D           | o not enter the mode of dying,                                   | such as cardiac or                         | respiratory arrest                       | u (Siccory)                                | Approximate<br>Interval Between                 |
| Due to (or as a consequence of):    Sequentially ist conditions cause. Enter Underlying is cause. Ente | 36       |   |        | disease or condition   | multiorgan                               | system fai   | ilure                                      |  |  |   |
| Due to (or as a consequence of):   Due to (or as    |          |   |        | resulting in dealing   |  | se of):  | 100  |  |  | 1410  |
| The string of death of the string in death) List    Due to (or as a consequence of):   |          | D =   | ner    | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying     |  | e of):   | 100  | 1 \                                      |  | 1 caucy   |
| Second   S   |          | and<br>I-trans                                      | xami   | that initiated events  | macribal                                 | Diaphragi  | malic                                      | henia                                    |  | 14 days   |
| FEMALE:   1   Was   2   No   1   | 760,     | sicien<br>buria                                     | aiE    |  | Due to (or as a consequent               | .e or <sub>j</sub> .   |  |  |  | -   |
| The state of the s | 9        | rtificate<br>ng phy<br>as the                       | Aedic  | VE 55444.5   |  |  |  |  |  |   |
| The state of the s | Box      | ath ce  | lan/A  | 23b. Was decedent pregnant 23c   | 1 ☐ Live birth 2 ☐ Fetat dea             |  |  |  |  | ,   |
| Color   Colo   |          | the de<br>y the e<br>iched f                        | ysic   | 1 ☐ Yes 2 ☐ No   |  | 5 Other (specify)  |  |  | Moriti                                     | Day Year  |
| Page      |          | ss thet<br>gned b                                   | by P   | Part II. Other significant conditions contr  | buting to death but not resulting        | g in the underlying cause given                                  | in Part I.                                 | 23e. Did tobac                           | co use contribute to the                   | ne cause of death?                              |
| 29a. Certifier (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  AND Brown, MD (00 N. Wolfe Sfreet Balkimare MD 72287  31. Date filed (Month, Day, Year)  32. Registrar's Signature  33. Date filed (Month, Day, Year)  34. Date filed (Month, Day, Year)  35. Registrar's Signature  | ord      | require   | ted    |  |  |  |  | 1 ☐ Yes                                  | 7CNo 3□ Prob                               | ably 4 Unknown                                  |
| 29a. Certifier (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  AND Brown, MD (00 N. Wolfe Sfreet Balkimare MD 72287  31. Date filed (Month, Day, Year)  32. Registrar's Signature  33. Date filed (Month, Day, Year)  34. Date filed (Month, Day, Year)  35. Registrar's Signature  | Rec      | has b   | mple   |  |  |  |  | autopsy                                  | 24b. Were auto                             | psy findings available<br>impletion of cause of |
| 29a. Certifier (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  AND Brown, MD (00 N. Wolfe Sfreet Balkimare MD 72287  31. Date filed (Month, Day, Year)  32. Registrar's Signature  33. Date filed (Month, Day, Year)  34. Date filed (Month, Day, Year)  35. Registrar's Signature  | tal      | en: Tr<br>tificete<br>tor, par                      |        | 25. Was case referred to medicat   |  | 2  | Of Phon of Dooth                           | 1 Yes                                    |  | 20 No   |
| 29a. Certifier (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  AND Brown, MD (00 N. Wolfe Sfreet Balkimare MD 72287  31. Date filed (Month, Day, Year)  32. Registrar's Signature  33. Date filed (Month, Day, Year)  34. Date filed (Month, Day, Year)  35. Registrar's Signature  | Ž        | hysici<br>his cer<br>i direc                        | ToB    | examiner?  | spitat:                                  | 0.00   |  |  | e 6 ☐Other (Specif                         | y)  |
| 29a. Certifier (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  AND Brown, MD (00 N. Wolfe Sfreet Balkimare MD 72287  31. Date filed (Month, Day, Year)  32. Registrar's Signature  33. Date filed (Month, Day, Year)  34. Date filed (Month, Day, Year)  35. Registrar's Signature  | o uc     | ding P  |        | Naturaf 5 ☐ Pending  | 28a. Date of Injury<br>(Month, Day Year) | Time of 28c. Injury at 12 Work?                                  | it 28                                      |  |  |   |
| 29a. Certifier (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  AND Brown, MD (00 N. Wolfe Sfreet Balkimare MD 72287  31. Date filed (Month, Day, Year)  32. Registrar's Signature  33. Date filed (Month, Day, Year)  34. Date filed (Month, Day, Year)  35. Registrar's Signature  | /isic    | Attence r death                                     | fical  | 3 Suicide 6 Could not be   | 28e. Place of Injury - At home,          |  |  | If Location (Stree                       | t and Number or Rura                       | I Route Number                                  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  ANUL Brown, UD 600 N. Wolfe Street Balkinuse MD 21287  State Registrar  31. Date filed (Month, Day, Year)  DEC 2 8 2005  32. Registrar's Signature   | á        | rs after a led in the                               | Cert   | 4   Homicide   | building, etc. (Specify)                 |  |  | City or Town, S                          | itate)                                     | , riouto riumbor,                               |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  ANUL Brown, UD 600 N. Wolfe Street Balkinuse MD 21287  State Registrar  31. Date filed (Month, Day, Year)  DEC 2 8 2005  32. Registrar's Signature   |          | the Hospi<br>in 24 hou<br>the Funer<br>pletely fill | edicai | (Check only / 2   Medical Examine  | r: On the basis of examination           | ge, death occurred at the time, and/or investigation, in my opin | date and place, an<br>tion, death occurred | d due to the caus<br>d at the time, date | e(s) and manner as stand place, and due to | ated.<br>the cause(s)                           |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  ANNA Brown, MD 600 N. Wolfe Street Balkinge MD 2287  State Registrar  State Registrar  DEC 2 8 2005  32. Registrar's Signature   | \ \      | To To To To To To To To To To To To To T            | Σ      | 29b. Signature and title of certifier  | 110                                      |  |  |  |  |   |
| State Registrar 31. Date filed (Month, Day, Year) 32. Registrar's Signature 32. Registrar's Signature  | <u>_</u> | $\prec$   |        | 30 Name and address of parties who see   | plated cause of death (the 20            |  | - 000                                      |  | 2Cember 2                                  | 3,2005  |
| State Registrar 31. Date filed (Month, Day, Year) 32. Registrar's Signature 32. Registrar's Signature  | 0        | L .   |        | A 1 0 1  |  |  | StreeL                                     | Balli                                    | more Mr                                    | 2297  |
| DHMH 17 Rev 1/2001   |          |   |        | 31. Date fited (Month, Day, Year)  | 32. Registrar's Signature                |  |  | 1-1-1-1                                  |  |   |
|  | DH       |   |        | BEU & O ZUL  | O Begges 15                              | gase   |  |  |  |   |

|  | 1 - State Registrar  1. Decedent's Name (First, Midd  | Items 1400,14   | Ce   | rtificate of                                   | Death                                      |  | Reg. No. [] [] 5                                 | 41851                                     |
|--|---|---|--|--|--|--|--|---|
| Physician                                | HATTLE  |   | DICK   |  |  | Month                                  | Day Year   | 3. Time of Death                          |
| /Medical<br>Examiner                     | As The City Manager of the Administration of  |   |  | 4b. City, Town, o                              | r Location of Death                        |  | 4c. County of De                                 |   |
| . 47                                     |   |   | HOSP TAL   |  | TIMON                                      |  | N/A  |   |
| eral<br>ctor                             | 5. Social Security Number 217-24-5623   | 6. Sex 7. Ag<br>1 ☐ M 2 X F   | e (In yrs. last birthday, 78 Yrs.                  | If Under 1 Year<br>Months Days                 | Hours Min.                                 | (Month, Da                             | 9. Bi<br>y, Year) 9. Bi<br>14, 1927              | rthplace (State or Fore<br>Country)<br>Md |
|  | Usual Residence of Decedent   |   | 10c. City, Town or Li                              |  |  | Phili                                  | 14,1741  |   |
| ō  |   | /   | Baltim   |  |  |  |  | 10d. Inside City Lim Yang Yes 2 □ I       |
| irect                                    | 10e. Street and Number  |   |  | 10f. Zip Code                                  |  |  | 10g. Citizen of What C                           |   |
| nce. To Be Completed by Funeral Director | 1581 Stonewo  | ood Road  |  |  | 21239                                      |  |  | U.S.A.                                    |
| une                                      | 11. Marital Status  | 12. Was Decedent<br>Armed Forces?   |  | Was Decedent of H<br>If Yes, specify Cuba      | lispanic Origin? (S<br>an, Mexican, Puert  | pecify Yes or No<br>o Rican, etc.)     | 14. Race · Am<br>Black, Wh                       |   |
| þ  | 3 ☐ Widowed 4√☐ Divorce   | If Yos Give   | 10   | 1□Yes X□No                                     | Specify:                                   |  | Specify: B                                       | lack                                      |
| Completed                                | 15. Deceder   | nt's Education<br>est grade completed)                                      | 16a. Dece  | dent's Usual Occup                             | nation<br>during most of wor               | kina                                   | 16b. Kind of Busines:                            | s/Industry                                |
| idmo                                     | Elementary/Secondary (0-12)   | College (1-4or 5  | 0+)  | kind of work done<br>DO NOT use retired        | d)   |  | Friends  | School                                    |
| Be Co                                    |   | Last)   | D  | ietary   | 18. Mother's Nam                           | ne (First, Middle,                     | Maiden Sumame)                                   | BCHOOT                                    |
| To B                                     | Frank K. Aug  | gins  |  |  | Virgi                                      | nia Gar                                | dner   |   |
|  | 19a. Informant's Name/Relation:<br>Marguerite Gi  |   | 19b. Maili<br>er 56                                | ng Address (Street                             | and Number or Ru<br>ran - Roac             | ral Route Numbe                        | or, City or Town, State,<br>More Md.             | Zip Code)<br>21212                        |
|  | 20a. Method of Disposition  |   | 20b. Place of Dispo                                | Lothi osition (Name of                         | an   | Date                                   | 20c. Location - City of                          |   |
|  | Magazial 2 ☐ Cremation<br>4 ☐ Donation 5 ☐ Other (  |   | Dulaney  | matory or other plac<br>Vallev                 | ·  | -27-05                                 | Timoniu  |   |
| ġ  | 21. Signature of Funeral Service  |   |  | 2. Name and Addre                              | ss of Facility                             | 1                                      | Jarris Fu  |   |
| once                                     | Jusel /   | UKS/  | 5  | 240 Reis                                       | stersto                                    | vn Rd E                                | Baltimore  |   |
|  | //  | r complications that caused<br>tonly one cause on each li                   | the death. Do not en                               | ter the mode of dyin                           | ig, such as cardiac                        | or respiratory ar                      | rest,  | Approximate<br>Interval Between           |
| an<br>al                                 | Immediate Cause (Final disease or condition resulting in death)   | a   | SEPSIS   | 3  |  |  | /  | Onset and Death                           |
|  |   |   | a consequence of):                                 | 70 4   | <b>~</b>                                   |  |  |   |
| ner                                      | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated expects) | Due to (or as   | RIN ARY a consequence of: a consequence of): FN AC | (/()/2   | 1 10 -                                     | ect to                                 | J  |   |
| Examiner                                 | Cause (Disease or injury that initiated events resulting in death) Last   | c. Due to (or as  | ABETES   | MEL  | 41111                                      |  |  |   |
|  |   | 200 10 (01 23   | FN A7  | INGLE  | 510.2n                                     | J. 10                                  |  |   |
| ledic                                    |   | 0   | .,,  | 71-507   |  | -/-                                    |  |   |
| Physician/Medical                        | iF FEMALE:<br>23b. Was decedent pregnant<br>in the past 12 months?  | 23c. If yes, outcome  |  | Dectopic pregnancy                             |  |  | 23d. Date of de                                  |   |
| ysici                                    | 1 Yes 2 No  | 4☐Pregnant at<br>9☐ Unknown   | time of death 5                                    | Other (specify)                                |  |  | Month  | Day Year                                  |
| by Ph                                    |   | ons contributing to death b   | ut not resulting in the u                          | nderlying cause give                           | en in Part I.                              | 23e. Did to                            | bacco use contribute to                          | o the cause of death?                     |
| ed b                                     | - COPD  |   |  |  |  | 1 □ Y                                  | es 2 No 3 P                                      | robably 4 Unkno                           |
| Completed                                | - HYPERT  | ENSION  |  |  |  | 24a. Was a                             | an 24b. Were a                                   | utopsy lindings availa                    |
| Con                                      | - COR 06  | ROVASCUL  | AR ACE   | IDENT 1  | UTH APHI                                   | SIN perfor                             | med? death?<br>2☐ 1☐ Yes                         |   |
| Be                                       | 25. Was case referred to medica examiner?   | Hospitali   |  | ot 30 DOA Othe                                 | 26. Place of Deal                          |  | -  |   |
| n: To                                    | 1 ☐ Yes 2 ☑ No<br>27. Manner of Death   | 28a. Date of Injur  | nt 2 ER/Outpatier  y 28b. Time o                   | IL 3L DOA                                      | 4 Linuising no                             |  | ence 6 Other (Spe                                | icify)                                    |
| atio                                     | 1 ☑Natural 5 ☐ Pendir<br>2 ☐ Accident investi   |   | / Year) Injury                                     |  | k?<br>Yes 2 □ No                           |  |  |   |
| Certification:                           | 3 Suicide 6 Could 4 Homicide determ   |   | ury - At home, farm, str<br>c. (Specify)           | eet, lactory, office                           |  | 281. Location (S<br>City or Tow        | treet and Number or Ri<br>n, State)              | ural Route Number,                        |
|  |   | Bhusisian Tathahas  |  |  |  |  |  |   |
| Medical Certific                         | (Check only 2 Medical   | ng Physician: To the best of<br>Examiner: On the basis of<br>and manner sta | examination and/or in                              | n occurred at the tim<br>vestigation, in my of | ne, date and place,<br>pinion, death occur | and due to the c<br>red at the time, c | ause(s) and manner as<br>late and place, and due | s stated.<br>e to the cause(s)            |
| Me                                       | 29b. Signature and title of certifie  | Λ   |  | 29c. License                                   |  |  | 29d. Date signed (Mont                           |   |
|  |   | DR MA   | W. N. 00 r   | 10 D OC  | 6223                                       | 9 2                                    | December 1                                       | 9,2005                                    |
|  | 30. Name and address of person  | who completed cause of g  | sain (Type,  | r ilit)  | 1  | ALTIA                                  | 400  |   |
| State                                    | 31. Date filed (Month, Day, Year)   | SAMARI7   | ar's Signature                                     | 25b 1200                                       | -, B                                       | 4LT/M                                  | MARE   |   |
| strar<br>İstrar                          |   | 8 2005  | we li  | Scorle   |  |  |  |   |

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** WILSON **ALONZO** RICHARDS 130 pm 23 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Square Franklin HOSPITal Rosedale Social Security Number 233-14-9757 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, **Funeral** Days Months Min. 1**X** M 2 □ F Hours 88 Director Yrs WEST VIRGINIA 7-15-1917 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location show 10d, Inside City Limits Item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, Ite Medical Examinar must be notified at MD BALTIMORE Director ROSEDALE 1 ☐ Yes 2\No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7909 35TH STREET 21237 U.S.A. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify Specify: WHITE 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Coltege (1-4or 5+) ELECTRICAL ENGINEER GLEN L. MARTIN 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 should be fi and Mental H is marked ot CLARENCE ALONZO RICHARDS **AMY** GRACE (WELLS) ဂ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) RALPH RICHARDS/ SON 7909 35TH STREET ROSEDALE, MD 21237 Health Item 27 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If Ite
ony injury or ot 1 Burial 2 Cremation 3 Removal from State BEL AIR MEMORIAL 12-29-2005 BEL AIR, MARYLAND 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility CVACH/ROSEDALE FUNERAL HOME 1211 CHESACO AVENUE ROSEDALE, MD 21237 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Dys Function Multiorgan /Medical Due to (or as a consequence of): Examiner howel Obstruction and large Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine attending physicien and for use as the burial-transit The law requires thet the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No 23d. Date of delivery 3 Ectopic pregnancy Year 4☐Pregnant at time of death 5 Other (specify) certificete hes been signed by the a rector, page 2 should be detached to 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 Probably 4 Wunknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed?
Yes 2 No 1 ☐ Yes 2 ☐ No 1 Yes After this certification funeral director. 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☑ No Medical Certification; To Be 26. Place of Death | Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 DOA 27. Mayner of Death 1 V Natural 28a. Oate of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident filled in by the Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after or To the Funeral Direct completely filled in by 4 Homicide ö 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) RES 0000 Mayta Boonsam 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bultimore MD 21237 DR Maythe Boonyapredee 9000 Franklin Square Drive 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar DEC 2 8 2005

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth Month Dev Yeer **Physician** 232005 YOSA1 2 /Medical 4b. City, Town, or Location of Death 4e Facility Neme (If not institution, give street end number) 4c. County of Death Examiner 1000 N GILMER BALD FUTURE SANOTOWN If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Jan. 14, 1928 7. Age (In yrs. lest birthdey) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex Funeral Days 1 □ M 2 🔀 F 215-24-4912 77 Maryland Director Usuel Residence of Decedent Pages 1 and 2 should be filed within 72 hours aftar deeth with the Merylend nant of Health end Mantel Hygiene. 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits Depermant of Health and Maniel Hygiana. Important: if Nem 27 is marked other than "natural", or Nema 23a or 28a-1 ahow any Injury or other traumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2 ☐ No Funeral Director Md. Baltimore 10e. Street end Number 10g. Citizen of Whet Country? 10f. Zip Code 1000 Gilmor Street 21217 USA 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Year or Dates: Specify: Black Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) House Keeping Hospital (City) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Lewis Brown Eula Jane Harris Brown 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 19e. Informant's Neme/Reletionship (Type, Print) Shrinda Harris (GrandDau 2554 Robb St.Baltimore, Md. 21218 20b. Place of Disposition (Name of cemetery, crematory or other p Date 20c. Location - City or Town, State 20a. Method of Disposition plece) 1⊠ Burial 2 ☐ Cremation 3 ☐ Removal from State Mt. Zion Cemetery 12/30/05 Landsdowne, Md. 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Fecility James E. Lincoln F/H P.A. 108 W.North Ave. Baltimore, Md 21201 ter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, heart failure. List only one cause on each line. Onset and Death **Physician** Immediate Cause (Final diseese or condition resulting in death) with Metastage /Medical Examiner Examiner or Attending Physician: The lew requires that the deeth certificate be executed the burial-transit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or injury that initieted events resulting in death) Last Due to (or as e consequence of): attending physicien end Box 68760, Physician/Medical Due to (or as a consequence of) Division of Vital Records, P.O. Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? eral Director: After this certificata has been signed by the signified in by the funeral director, pega 2 should be detached 1 Yes 2 LNO 3 Probably 4 Unknown þ 24b. Were eutopsy findings aveilable prior to completion of cause of deeth? least Failurg 24a. Was an autopsy performed? Completed 1 Tyes 2 No 1 ☐ Yes 2 ☐ No After this certificate 25. Wes case referred to medical examiner? Be 26. Piece of Death (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 28c. Injury et Work? 27. Menner of Death 28e. Dete of Injury (Month, Dey Year) 28b. Time of Injury 28d. Describe how injury occurred edical Certification: 1- Natural 5 Pending investigation 1 Yes 2 No after deeth. 2 Accident Director: 3 ☐ Suicide 6 Could not be determined 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 4 Homicide To the Hospital e within 24 hours a To the Funeral D 1 Cortifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. 29a. Certifier 29c. License number 29d. Date signed (Month. Dev. Year) 29b. Signature end title of certifier Neme end address of person who completed cause of geeth (Item 23e) (Type, Print) RD BALTO MD 21211 419 FALLS UBEROI 4e115 31. Date filed (Month, Dey, Year) 32. Registrer's Signeture State

DHMH 16 Rev 6/95

Registrar

8 2005

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend items 17 18 19a per fth 863 1-5-07 vt
State of Maryland 7 Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg No.U U 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav Year **Physician** ROGAN 8=15PM JULIA MACHIN 15 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner UNIVERSITY OF MARYLAND MED. CTR BALTIMORE **Baltimore City** 7. Age (In yrs. last birthday) | If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 X F n Director none December 11, 2005 Maryland Usual Residence of Decedent the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State 7 is marked other than "natural", or itame 23a or 28a-f show traumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2 No Director Maryland Howard Columbia 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21045 U.S.A. 9103 Brunners Run Ct. death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give! Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Infinortant: if item 27 is marked other than "natural", or ital any injury or other traumatic event, the Medical Examira 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: à Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry never worked Elementary/Secondary (0-12) College (1-4or 5+) never worked n/a 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)

Allyson Paige Buck Be Steven W. Rogan -Steven V. Rogan 19a. Informant's Name/Relationship (Type, Print)
Steven W. Rogan 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9103 Brunners Run Ct. Columbia, Maryland 21045 Mr. Steven Regen Father 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 □ Donation 5 □ Other (Specify) 12/21/2005 Clarksville, Maryland Columbia Memorial Park 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Slack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott Cirshock, or heart failure. List only one cause on each line. Slack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043 Approximate Interv*a*l Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Intraventricular Physician Severe Hemorrhage /Medical Due to (or as a consequence of): Examiner Distress Syndrome Respisatory Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or s a consequence of): Examiner Interstitial burial-transit Pulmonary and Due to (or as a consequence of): the attending physician hed for use as the buria Division of Vital Records. P.O. Box 68760 Prematurit 8 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Dav Year 4 Pregnant at time of death 5 Other (specify) be detached 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☑ Yes 2 ☐ No 24a. Was an this certificate has autopsy performed? 1 ☑ Yes 2 No Hospital or Attending Physician: 24 hours after death. filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death | Check only one) Hospital: 1 Inpatient examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 1 No Certification: To 2 ER/Outpatient 3 DOA 27, Manuer of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b Time of 28d. Describe how injury occurred Director: After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homicide To the Hospital i within 24 hours at To the Funeral D 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Dev. Year) P18664 Madhan.S 12/15/2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SANGEM 22 S GREENE STREET , UMMS MADHAVI Sources 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 8 2005 and the Registrar

|  | State of Maryland / Department of Health and Mental Hygiene  1- State Registrar  Certificate of Death  Reg. No.  | 5 41855  |
|--|--|--|
| Physician  | 1. Decedent's Name (First, Middle, Last)  2. Date of Death   | 3. Time of Death   |
| Physician<br>/Medical  | RICHARD W. RICHARDSON 12 - 25 - 20  4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of  | 005 8:15 P.M   |
| Examiner   |  | BALTIMORE  |
| Funeral<br>Director  | 5. Social Security Number 220-07-4776 XXI M 2 F 89 Yrs. Social Security Number 220-07-4776 XXI M 2 F 89 Yrs. Social Security Number 24 Hrs. Social Security Number 24 Hrs. Social Security Number 220-07-4776 XXI Months Days Hours Min. Min. Min. Min. Min. Min. Min. Min.  | 9. Birthplace (State or Foreign Country) NORTH CAROLINA              |
| aryland ehow   | 10a. State 10b. County 10c. City, Town or Location   | 10d. Inside City Limits  |
| with the Maryls a or 28a-f eho<br>be nutilised at  | MD. BALTIMORE TOWSON   | 1 ☐ Yes 🌂 XNo  |
| 3a or 3  | 10e. Street and Number 10f. Zip Code 10g. Citizen of W 1. S  | S. A.  |
| d 21215-0036 Illed within 72 hours after death with the Maryland Hygiene. Hygiene. Inter than "natural; or items 23s or 28s-f show ent, the Macilical Exercitmer: shall be netillised at a Completed by Funeral Director   |  | e American Indian,<br>k, White, etc.                                 |
| 5-00 72 hou natura   | 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Bus (Specify only highest grade completed) (Give kind of work done during most of working   | siness/Industry  |
| Maryland 21215-0036 d2 should be filed within 72 hours att th and Martal Hygiens 17 is marked other than "natural", or traumatic event, the Medical Exercitations of Be Completed by F   | life DO NOT use retired  | RE SUN PAPER   |
| ind 21 be filed wital Hygien d other the event, the  | 17. Father's Name (First, Middle, Last)  18. Mother's Name (First, Middle, Maiden Sumame   | ,  |
| Maryland<br>d 2 should be i<br>th and Manta I<br>it is marked of<br>treumatic eve  | WILLIAM GALLOWAY RICHARDSON MADELINE M'LISS F  19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, S  | FREED  |
| C = 01 F   | DOTTIE R. WOOTERS (DAUGHTER) 912 BREEZEWICK CIRCLE, TOWSON, MARYLA   |  |
| S S T I I  | Cemetery, Crematory or other place)  | City or Town, State  |
| Baltimo<br>permit. Pag<br>Department<br>important: It<br>eny injury o  | 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 1050  | YORK ROAD<br>SON,MD.21204  |
|  | 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.   | Approximate<br>Interval Between<br>Onset and Death                   |
| Physician<br>/Medical  | Immediate Cause (Final disease or condition resulting in death)  a.   School   | years  |
| Examiner   | Sequentially list conditions, b  |  |
| 0, 5/05<br>oxecuted<br>in and<br>irial-transit   | Sequentially list conditions, flamy, leading to minipolate cause. Enter Underlying Cause (Disease or injury  |  |
|  | that initiated events ' c. resulting in death) Last Due to (or as a consequence of):   |  |
| , 0 \( \bar{\pi} \) \( \p      | IF FEMALE:   | 200100-00  |
| ords, P.O. Box (requires that the death certification bedied by the attending hould be detached for use a steed by Physician/Me  |  | e of delivery<br>th Day Year   |
| IS, P. Is that the strength be detaced by Physics by Ph | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   | bute to the cause of death?  |
| Cords w require been sig   | 1 \ Yes 2 \ No   | 3 Probably 4 □Unknown  |
| I Re la The la ate has page 2  | autopsy pr<br>performed? di<br>1 □ Yes 2 20No 1 (  | fere autopsy findings available rior to completion of cause of eath? |
|  | 25. Was case referred to medical examiner?  1  Yes 2 No  | r (Specity OSPL)   |
| on of ding Phys funeral di   | 27. Manner of leath 28a. Date of Injury (Month, Day Year)  28b. Time of logury at Work?  28d. Describe how injury occurre  |  |
| Division C Division C Division C  124 hours after death  184 hours after death  184 hours after death  184 hours after death  184 hours after death  184 death  185 death  185 death  185 death  185 death  185 death  | 2 Accident investigation   M   1 Yes 2 No   3 Suicide   6 Could not be determined   Street and Number   St | r or Rural Route Number,   |
| [d. 5]   | 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and man content with the course of the cause of the c | ner as stated.   |
| To the Hose within 24 h To the Fur completely Medical  | oney and manner stated.  | (Month, Day, Year)   |
| F × 2 8  |  | ~ 26 2005  |
| 8+1  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  ADAM SO CHAMLER WO LIGOT N. Charle St Powrow, wo 21204   |  |
| State<br>Registrar   | 31. Date filed (Month, Day, Year) DEC 2 8 2005 32. Registrar's Signature   |  |

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State

Registrar

31. Date filed (Month, Day, Year)

DEC 2 8 2005

|                            |   |                             | Pleas  | Chate of Mondand                                     |   |   |  | realpio.                      |  |
|----------------------------|---|-----------------------------|--|--|---|---|--|-------------------------------|--|
|                            |   | 1                           | For<br>State<br>Registrer  | State of Maryland                                    | Certificate of  |   | Reg. N   |                               | 41857  |
|                            |   |                             | Decedent's Name (First, Middle, )  | Last)  |   |   | . Date of Death<br>Month Da  |                               | 3. Time of Death                                   |
| Ш                          | Physicia  |                             | Alexander  | R. Spiver  | -V TIT  |   |  | 2005                          | - 6:50 M   |
|                            | /Medic<br>Examin  |                             | a. Facility Name (If not institution, g  | rive street and number)                              |   | r Location of Death                     |  | . County of Dea               | th   |
|                            |   |                             | 22 Tamers  | Ct.  | st birthday) If Under 1 Year  | MOTE If Under 24 Hrs. 8                 |  |                               | More.  |
|                            | Funeral   |                             |  | Sex 7. Age (In yrs. la:                              | Yrs. Months Days  | Hours Min.                              | Date of Birth<br>(Month, Day, Year<br>(Month, Day, Year  |                               | thplace (State or Foreign<br>puntry)               |
|                            | Director  |                             | 214-58-9613<br>Usual Residence of Decedent   |  |   |   | 01-01-7  | 7                             | /            |
|                            | nyland<br>how   |                             | 10a. State 10b. County   | 10c. City,   | Town or Location  |   |  |                               | 10d. Inside City Limits 1 □ Yes 2 □ No             |
|                            | 8e-f s  | Director                    |  | imore /  | 10f. Zip Code   |   | 10a C  | itizen of What Co             |  |
|                            | with the  |                             | 10e. Street and Number   | 11   | 212   | 11.16                                   |  | 115                           | 9  |
|                            | ns 23   | Funerai                     | 22 / amers   | 12. Was Decedent Ever in U.S                         |   |   | fy Yes or No-  | 14. Race - Ame<br>Black, Whi  |  |
| 9                          | ours after death with the Marylan<br>rel', or Items 23a or 28e-f show<br>Examiner must be notified at                 | 필                           | 1 Never Married 2 Marrie   | Armed Forces?  1 MYes 2 □ No !fYes, Give             | 1 🗆 Yes 25 No   | Specify:                                | Call, 8(C.)  | Specify:                      | , 610.   |
| 5-0036                     | 72 hours after death with the Maryland<br>naturel', or Items 23a or 28e-f show<br>dical Examiner must be multified at | d by                        | 3 Widowed 4 Divorced   | Year or Dates:                                       |   |   | 165  |                               | ack  |
| <u>7</u>                   | n 72 hours<br>"naturel",<br>edical Ex   | Completed                   | 15. Decedent's<br>(Specify only highest  | grade completed)                                     | 16a. Decedent's Usual Occup<br>(Give kind of work done<br>life. DO NOT use retire | during most of working                  |  | , I                           | a mada iy  |
| 2121                       | within<br>iene.<br>than "   | omp                         | Elementary/Secondary (0-12)  | College (1-4or 5+)                                   | Computer  | Analyst                                 | Jo   | bas Ho                        | pkins UNIV.  |
|                            | e filed<br>Il Hygi<br>other<br>vent, Il   | BeC                         | 17. Father's Name (First, Middle, L.   | ast)   |   | 18. Mother's Name (                     | First, Middle, Maide   | n Sumame)                     |  |
| /lar                       | 2 should be filled withli<br>and Mental Hygiene.<br>Is marked other than<br>sumatic event, II v M                     | 2                           |  | pivery It  |   | Earline                                 |  | 5                             | 7.0-4)   |
| Maryland                   | 2 pg 28   | N I                         | 19a. Informant's Name/Relationshi  | p (Type, Print) (Friend)                             | 19b. Mailing Address (Street  | and Number or Hural                     | 77.11  |                               | zip Code)  |
|                            | s 1 and 2<br>f Health<br>Item 27<br>other tr  | 1                           | Debra Kuri<br>20a. Method of Disposition   | - ( V ) 20b. Pla                                     | ace of Disposition (Name of   | 105 her 50                              | The second secon | More //<br>Location - City or | Town, State  |
| nor                        | ages<br>ant of<br>t: If It<br>y or o  |                             | 1 Surial 2 ☐ Cremation<br>4 ☐ Donation 5 ☐ Other (Sp.  | Removal from State                                   | rrison Forest   |   | 7-2005 04  | sings 1                       | lills Nid.   |
| Baltimore,                 | permit. Page:<br>Department o<br>Importent: If<br>any injury or<br>once.  |                             | 21. Signature of Funeral Service L   |  | 22. Name and Addre  | ess of Facility                         | ineral H   | ome P.                        | A  |
| Ä                          | Depare<br>Important   | 85 p                        | Josephi  | 8. Russ  | 222200  | ess of Facility<br>RUSS FU<br>Worth Aug | Bultin   | iore, mi                      | d. 21216   |
|                            |   |                             | 23a. Part1. Enter the disease, or of shock, or heart failure. List of  | omplications that caused the deeth                   | . Do not enter the mode of dyi  | ng, such as cardiac or                  | respiratory arrest,  |                               | Approximate<br>Interval Between<br>Onset and Death |
|                            | Physician   |                             | Immediate Cause (Final disease or condition resulting in death)  | - Artenioscler                                       |   | vascular                                | VISLase  |                               | loyears  |
|                            | /Medical<br>Examiner  |                             | 1030Alling III GOGATI)   | Due to (or as a consequ                              | ence of):   |   |  |                               |  |
|                            |   | ē                           | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that leithed events.   | b. Due to (or as a consequ                           | ience of):  |   |  |                               |  |
| +                          | cuted<br>nd<br>ransit   | Examiner                    | tilat ilitiated events   | C  |   |   |  |                               |  |
| ,<br>0                     | certificate be executed adding physician and use as the burial-transit  |                             | resulting in death) Last   | Due to (or as a consequ                              | ence of):   |   |  |                               |  |
| 68760                      | cate b  | dical                       | 23   | d  |   |   |  |                               |  |
| 9 X                        | ding p  | /Me                         | IF FEMALE:<br>23b. Was decedent pregnant   | 23c. If yes, outcome of pregnar                      | ncy   |   |  | 23d. Date of de               | əlivery  |
| Вох                        | that the death certificate<br>ed by the attending phys<br>detached for use as the                                     | Completed by Physician/Medi | in the past 12 months?   | 1 Live birth 2 Fetal                                 |   |   |  | Month                         | Day Year   |
| P.O.                       | it the oby the tacher   | hys                         | 9 🗆 Unknown  | 9□ Unknown   |   |   | og Biddebee  |                               | to the cause of death?                             |
|                            | w requires that the<br>s been signed by th<br>should be detache   | by F                        | Part II. Other significent condition   | ns contributing to death but not resu                | ulting in the underlying cause g  | iven in Part I.                         |  | 2 □ No 3 □ F                  |  |
| ord                        | requir  | eted                        |  |  |   |   | 24a. Was an  |                               | autopsy findings available                         |
| 3ec                        | has<br>has  | mple                        |  |  |   |   | autopsy<br>performed   | prior to                      | completion of cause of                             |
| a                          | iclan: The la<br>certificate ha<br>rector, page 2   | e Co                        | 25. Was case referred to medical   |  |   | 26. Place of Death                      | (Check only one)   | No 1 ☐ Ye                     | as 240 No  |
| 5                          |   | To B                        | examiner?<br>1 X Yes 2 □ No  | Hospital: 1   Inpatient 2                            | ER/Outpatient 3 DOA   | thos                                    | ne 5 Residence   | 6 ☐ Other (Sp                 | ecify)   |
| Jot                        | ding Phys<br>h.<br>After this<br>funeral di   | J.i.                        | 27. Manner of Death  | 28a. Date of Injury<br>(Month, Day Year)             | 28b. Time of lnjury 28c. Injury   | ork?                                    | 8d. Describe how in  | jury occurred                 |  |
| Siol                       | Attending or death. ector: After by the fune  | catic                       | 2 Accident investig  | ation  |   | Yes 2 No                                | 8f Location (Street  | and Number or I               | Rural Route Number,                                |
| Division of Vital Records, | or At<br>after d<br>Direct<br>in by   | ertifi                      | 4 Homicide determine   | ned building, etc. (Specify                          | ome, farm, street, factory, office  | ,                                       | City or Town, St   | ate)                          |  |
|                            | To the Hospital or Attend within 24 hours after death To the Funerel Director: completely filled in by the            | Medical Certification:      | 29a. Certifier 1☐ Certifyin  | g Physician: To the best of my kno                   | wledge, death occurred at the   | time, date and place, a                 | nd due to the cause  | (s) and manner                | as stated.   |
|                            | n 24 h  | edic                        | (Check only 2 Medical one)   | Examinar: On the basis of examina and manner stated. |   |   |  |                               |  |
|                            | To the within 2 To the comple   | Σ                           | 29b. Signature and title of certifier  | 1 - A (1)  |   | nse number                              |  | Date signed (Moi              |  |
|                            | 4   |                             | C STATE OF THE STA | . Dobnin   |   | 8667                                    |  |                               | 127,2005   |
|                            | 6   |                             | 30. Name and address of person   | who completed cause of death (Item                   | Trimble H   | : 11 CT. Lu                             | thenville  | Maryl                         | and 21093  |
|                            |   | ate                         | 31. Date filed (Month, Day, Year)  | 32 Registrar's Signa                                 |   |   |  | ,                             |  |
|                            |   | rar                         | DEC 2 8  | 2005 180   | Property D  |   |  |                               |  |

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend item#19b perith (851,1/10/06 TI State of Maryland / Department of Health and Mental Hygiene 1- State Amend Item 10e per FH G850 12/28/05c GC of Death Regulation U 5 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Year Sewell December 20 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Gry God medical NA Cotes LAIVEBITY C If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 10 - 16 - 1918 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 1**Ø**.M 2□ F Months Min. 87 Director 201-10-2733 Vrs MD Usual Residence of Decedent the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits \*how itsm 27 is marked other than "natural", or items 23a or 28a-f shov other traumatic event, the Madical Examinar in ust be notified at Director MD HANOVER 1 Tyes 2 No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? WIT 7516 RIDGE ROAD 21076 USA 21076 Funeral death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, permit. Pages 1 and 2 should be filed within 72 hours after or Department of Health and Mental Hygiene. Innortant: If itsm 27 is marked other than "natural; or item any injury or other traumatic svent, the Medical Exeminat Once. Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 XYes 2 No Saltimore, Maryland 21215-0036 Specify: BLACK 1 ☐ Yes 2 No δ 3 ☐ Widowed 4 🗖 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Coltege (1-4or 5+) LABORER 6 1H GRADE FT. MEADE MD. NA 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) JOHN F. SEWELL MARJORIE OLIVER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1402 HONTFORD DR. DAVIDSONVILLE MD 21035 SISTER) ILEANA M. TURNER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) CROWNSVILLE 12.30.05 CROWNSVILLE MD 21. Signature of Funeral Service Licensee VAUGHN C. GREENE FUNERAL SERVICE 5151 BALIO. NATI. PIKE, BALIO. MD 21229 Vanch 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) Clas /Medical Due to (or as a consequence of) Examiner abscess pinal flany, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a co-sequence of been signed by the attending physicien and should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. law requires that the death certificate be Physician/Medical IF FEMALE: 23c. tf yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Month 4☐ Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗓 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 2 No 2 1 No 1 ☐ Yes 1 🗌 Yes To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifice 25. Was case referred to medical examiner?
1 Tyes 2 DNo Be 26. Place of Death | Check only one | Hospital: 1 Impatient Other: မ 2 ER/Outpatient 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 3 DOA funeral 27. Manns of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? Certification: 28d. Describe how injury occurred 1 Le atural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Ptace of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) AU4176435K1581A December 23 2005 4 30. Name and addr of who completed cause of death (Item 23a) (Type, Print) 22 tinore, mo 21201 31. Date filed (Month, Day, Year) DEC 2 8 2005 32. Registrar's Signature

DHMH 17 Rev 1/2001

State Registrar

|                                |  |                   | For State Registrar  | State of Ma  | arylan                            |   | artment of I                                |   |   | giene                                  | 5 41859  |
|--------------------------------|--|-------------------|--|--|-----------------------------------|---|---|---|---|--|--|
|                                | Physici<br>/Medio  | cal               | 1. Decedent's Name (First, Middle, Las<br>Veronica Katheri   | ne Scott   |                                   |   |   |   | 2. Date of De                             | 23 21                                  | 3. Time of Death   |
|                                | Examir<br>Funeral  | ier               | 4a. Facility Name (If not institution, gives  5. Social Security Number 6. Se  | Spital   |                                   | ast birthday)                             | Baltimo                                     | II Under 24 Hrs                           | 8. Date of Bir                            | 4c. County                             | 9. Birtholace (State or Foreign  |
|                                | Director   |                   | Usual Residence of Decedent  | □ M 2(X)F  | 87                                | Yrs.                                      | Months Days                                 | Hours Min.                                | May 5,                                    | 1918 W                                 | Vest Virginia  |
|                                | 172 hours after death with the Maryland<br>"naturel", or iteme 23a or 28e-1 ehow<br>adical Exemenation or diffied at   | Director          | Maryland 10b. County   |  | Bu                                | 1. Town or Low                            | de  |   |   |  | 10d. Inside City Limits 1X Yes 2 □ No  |
|                                | 3a or 3  | בוב               | 10e. Street and Number 613 North Denison   | Street   |                                   |   | 10f. Zip Code 21229                         | 9   |   | 10g. Citizen of W                      | hat Country?   |
|                                | ome 2  | Funerai           | 11. Marital Status   | 12. Was Decedent E<br>Armed Forces?                                    | ver in U.                         | S. 13. V                                  |   | Hispanic Origin? (S<br>ban, Mexican, Puer | Specify Yes or No                         |  | e - American Indian,<br>k, White, etc.   |
| 9200                           | hours afte<br>urel', or it   | by                | 1 Never Married 2 Married 3 Widowed 4 Divorced   | 1 ☐ Yes 2 X N<br>tf Yes, Give<br>Year or Dates:                        | lo                                | 1   | ☐ Yes 2🕅 No                                 | Specify:                                  |   | Specify:                               | White  |
| 1215-                          | within 72<br>ene.<br>than "nat   | Completed         | 15. Decedent's Ed<br>(Specify only highest gra<br>Elementary/Secondary (0-12)  | ucation<br>de completed)<br>College (1-4or 5                           | +)                                | 16a. Deced<br>(Give I<br>life. D<br>Nurse |   | pation<br>during most of wo<br>ad)        | rking                                     | 16b. Kind of Bus                       |  |
| nd 2                           | e filed<br>al Hygi<br>other<br>vent,   | Be Co             | 17. Father's Name (First, Middle, Last)  |  |                                   |   |   | 18. Mother's Nar                          | me (First, Middle,                        | Maiden Sumame                          | θ)   |
| ylaı                           | i Menta  | 70 E              | Anthony Sekeley  |  |                                   |   |   | Anna Se                                   |   |  |  |
| Mar                            | od 2 sh<br>lith and<br>27 le m<br>r traum  |                   | 19a. Informant's Name/Relationship (7) Thomas Vinson/Son   | ** *   |                                   |   |   | tand Number or Au  Lane, B                |   |  | State, Zip Code)<br>, WV 25411   |
| Baltimore, Maryland 21215-0036 | permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 ie marked other than "naturel", or iteme 23a or 28e-f ehow arry injury or other traumatic event, the Madical Experiment must be notified at any injury or other traumatic event, the Madical Experiment must be notified at any of the second of the seco |                   | 20a. Method of Disposition  117 Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify   |  | Mea                               | ace of Dispos                             | sition (Name of                             | Pk. Dec                                   | Date                                      |  | City or Town, State  |
| Balti                          | permit. Departn Importa any inju   |                   | 21. Signature of Foneral Service Licen   | 1  |                                   | Wi  |   | ess of Facility<br>neral Hom<br>ndson Ave |   |  |  |
|                                | Physician<br>/Medical<br>Examiner  |                   | 23a. Part1. Enter the disease, or comp<br>shock, or heart failure. List only of<br>mmediate Cause (Final<br>disease or condition<br>resulting in death)  | a. Covoran  Due to (or as a  | e.                                | Arter                                     | er the mode of dyli                         | ofic V                                    | or respiratory ai                         | rrest,                                 | Approximate<br>Intervat Between<br>Onset and Death   |
| 8760,                          | certificate be executed iding physicien and ise es the burial-transit  | dical Examiner    | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last   | b. Due to (or as a c. Due to (or as a d                                |                                   |   |   |   |   |  |  |
|                                | The law requires that the death certifics the has been signed by the attending pt age 2 should be detached for use es to   | Physiclan/Medical | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown  | 23c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at 1 9 □ Unknown | 2 🗌 Fetal                         | death 3 🗌                                 | Ectopic pregnance<br>Other (specify)        | у   |   | 23d. Date<br>Mon                       | e ol delivery<br>th Day Year   |
| S C                            | v requires that<br>been signed t<br>should be det  | by                | Part II. Other significant conditions of   | entributing to death bu  | t not resu                        | lting in the un                           | derlying cause giv                          | ven in Part I.                            |   |  | bute to the cause of death?<br>3 ☐ Probably 4 Minknown                                     |
|                                |  | e Completed       | 25. Was case referred to medical   |  |                                   |   |   |   | 1 ☐ Yes                                   | osy pr<br>rmed? de<br>2000 1 [         | /ere autopsy lindings available<br>rior to completion of cause of<br>eath?<br>□ Yes 2 1 10 |
| Z.₹                            | ysicien: 1<br>is certificet<br>director, p   | To Be             | examiner?  | Hospital:  | nt 2 🔀                            | R/Outpatient                              | 3□ DOA Ctt                                  | or:                                       | ath <i>Check only o</i><br>lome 5 ☐ Resid | ne)<br>dence 6 ∏Othei                  | r (Specify)  |
| EV (                           | ttending Ph<br>death.<br>stor: After th<br>the funeral   |                   | 27. Manner of Death  1 Alatural 5 Pending 2 Accident investigation   | 28a. Date ol Injun<br>(Month, Day                                      | /                                 | 28b. Time of<br>Injury                    | 28c. Injur<br>Wor                           |   |   | now injury occurre                     |  |
| Divis                          | or A<br>lifter<br>in by  | Certification;    | 3 Suicide 6 Could not be<br>4 Homicide determined  | 28e. Place of Inju<br>building, etc.                                   | ry - At hor<br>. (Specify)        | me, farm, stre                            | et, lactory, office                         |   | 28f. Location (S<br>City or Tow           | Street and Number<br>vn, State)        | or or Rural Route Number,  |
|                                | To the Hospital within 24 hours a vithin 24 hours a To the Funerel I completely filled   | edical            | 29a. Certifier (Check only one)  1 Certifying Phy 2 Medical Exam   | rsician: To the best of iner: On the basis of and manner state         | examınatı                         | vledge, death<br>on and/or invi           | occurred at the tire<br>estigation, in my o | me, date and place<br>opinion, death occu | , and due to the orred at the time,       | cause(s) and man<br>date and place, ar | nner as stated.<br>nd due to the cause(s)  |
|                                | To the within To the comple  | Me                | 29b. Signature and title of certifier  | >  |                                   |   | 29c. Licens                                 | se number                                 |   | 29d. Date signed                       | (Month, Day, Year)   |
| 0                              | A  |                   | of the   | rieren 1   | N                                 | )   | 17  | 7005584                                   | 9 1                                       | December                               | r 23 2005  |
| 6                              |  |                   | 30, Na a and dress of person who of the second state of the second | St. /-   | ath (Item<br>19 ne<br>r's Signati | 23a) (Type, F                             | rint)                                       | 1 900                                     | Catout                                    | henve,                                 | r 23 2005<br>13altimore/<br>Marylant   |
|                                | Sta<br>Registr   | 0.00              |  | 005  | as J                              | N. A.                                     | 2340  |   |   | /                                      | marylan J  |

State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No. U U 5 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Th Year 24 2005 **Physician** SPURRIEJ2 recember 7 · 10 AM DONALD /Medical 4c. County of Death 4a, Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Baltimore Randallstown Northwest Hospital Center If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 6. Sex 1 M 2 □ F 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Yea Birthplace (State or Foreign Country) **Funeral** 1926 216-20-2374 79 June 4, Maryland Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10c. City. Town or Location 10a State 10b. County r than "netural", or iteme 23s or 28s-f show the Medical Examiner must be notified at 1 Yes 2 No Baltimore Baltimore Direct 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number United States 21244 7602 Clays Lane Apt 118 Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No 1944 -If Yes, Give Year or Dates: 1946 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. permit. Peges 1 and 2 should be filed within 72 hours after a Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "netural; or iter eny injury or other traumatic event, its Medical Examinat 1 ☐ Never Married 2 Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 📉 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Proctor & Gamble 10 Factory Worker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ethel B. Dennis Harry R. Spurrier ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7602 Clays Lane Apt 118 Baltimore, MD 21244 Doretta Spurrier Wife Date 28, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Dec. 2005 1∑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Domation 5 ☐ Other (Specify) Lorraine Park Cemetery Woodlawn, Maryland 21. Signature of Funeral Service Licenses <sup>22</sup> Name and Addr ss of Facility Burrier-Queen Funeral Home & Crematory, P.A. 1212 W. Old Liberty Road Winfield, MD 21784 amos 231. Part1. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immedia e Cause (Final dise e or condition resulting in death) **Physician** CARDIOMYODATHY /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dualto (or as a consequence of): Examine Hospitel or Attending Physician: The law requires that the death certificate be executed ettending physicien and for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No 5 ☐ Other (specify) 4☐Pregnant at time of death ed by the detached 9 Unknown 9 Unknown signed by t Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ MORENY DISEASE, HYDERTENSION, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? WIAMERS MELLINS. CEREBRO MISCHARDISTABE 24a. Was an page 2 autopsy performed? certificate 1 Yes 2 No 1□ Yes 2 1No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٩ 1 Yes 2 HO 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Yeer) 28b. Time of Injury 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? Certification: After 1 Hatural 5 Pending 1 Yes 2 No death. investigation 2 Accident Director: 3 🗌 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funeral ( 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Dey, Year) 29c. License number 29b. Signature and title of certifier 10 MD D54288 Kan Notitives Hemilal cente 30 Name and address of person who completed cause of death (Item 23a) (Type, Print) RAM GAMANA. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

|            |   |                  | 1 - For<br>State<br>Registrar  | State of Marylar  | id / Depa                     |                            | t of H                                | ealth an                       |              | -                                   |                    | CUU.                           |                   | 361                     |
|------------|---|------------------|--|---|-------------------------------|----------------------------|---------------------------------------|--------------------------------|--------------|-------------------------------------|--------------------|--------------------------------|-------------------|-------------------------|
|            | Physic  | an               | Decedent's Name (First, Middle, Las  | •   |                               |                            |                                       |                                | 1            | 2. Date of De<br>Month              | eath<br>Da         | y Year                         | 3. Time           | of Death                |
| 1          | /Medi   |                  |  | nann Sauter   |                               |                            |                                       |                                |              | Dec.                                | 24                 | 2005                           | 2:50              | ) P M                   |
|            | Examir  | ner              | 4a. Facility Name (If not institution, give  |   |                               |                            |                                       | Location of [                  |              |                                     | 40                 | : County of Deat               |                   |                         |
|            | Comment.  |                  | Chapel Hill Nurs 5. Social Security Number 6. Se   |   | last hirthday)                |                            |                                       | 11stow<br>If Under 24          | n<br>Hrs. is | B Date of Ri                        | rth                | Baltir                         |                   | to ou Comina            |
|            | Funeral<br>Director   |                  |  | □M 2√2F 7   |                               | Months                     | Days                                  |                                | Min.         | B. Date of Bid<br>Month, Da<br>July | Year               | 927 Man                        | untry)<br>Cy Lanc | te or Foreign           |
|            | <b>p</b> .  |                  | Usual Residence of Decedent  |   |                               |                            |                                       |                                |              |                                     |                    |                                |                   |                         |
|            | r 28a-f ehow  | _                | Maryland Balt  | imore 10c. Cit  | y, Town or Lo<br>Baltin       |                            |                                       |                                |              |                                     |                    |                                |                   | City Limits             |
|            | the M   | ecto             | 10e. Street and Number   | Zinore  | Darti                         |                            |                                       |                                |              |                                     |                    |                                |                   | es 2X No                |
|            | 2 A   | Funeral Director | 7529 Clays Lane  |   |                               | 10f. Zip                   |                                       | 244                            |              |                                     |                    | tizen of What Co               |                   |                         |
|            | ne 23   | era              | 11. Marital Status   | 12. Was Decedent Ever in U  | .S. 13.1                      | Was Deced                  |                                       |                                | ? (Spec      | ifv Yes or No                       |                    | 14. Race - Ame                 |                   |                         |
| 9          | or ite  | 교                | 1 Never Married 2 Married  | Armed Forces?<br>1 ☐ Yes 2/CXNo   |                               |                            |                                       | spanic Origin<br>n, Mexican, P | Puerto R     | ican, etc.)                         |                    | Black, White                   | e, etc.           | '                       |
| 5-0036     |   | d by             | 3 ☐ Widowed 4 ☐ Divorced   | If Yes, Give<br>Year or Dates:  |                               | 1□Yes :                    | 2LX.No                                | Specify:                       |              |                                     |                    | Specify:                       | √hite             |                         |
| 5-0        | 72  | Completed        | 15. Decedent's Ed<br>(Specify only highest grad  | ucation<br>de completed)  | 16a. Deced                    | dent's Usua<br>kind of woi | al Occupa<br>rk done d                | ition<br>uring most of         | f working    | 7                                   | 16b. K             | (ind of Business/              | ndustry           |                         |
| 2121       |   | ם                | Elementary/Secondary (0-12)  | College (1-4or 5+)  | 1                             | no not us<br>Homema        |                                       | , -                            |              |                                     |                    | wn home                        |                   |                         |
| d<br>2     | Hygin ther  | ပိ               | 12th  17. Father's Name (First, Middle, Last)  |   | -                             |                            | · · · · · · · · · · · · · · · · · · · | 18. Mother's                   | Name /       | First Middle                        | 1                  |                                |                   |                         |
| an         | id be<br>ental<br>ked c   | To Be            | Alfred A. Lehm   | ann   |                               |                            |                                       |                                |              | na Fis                              |                    | •                              |                   |                         |
| Maryland   | s 1 and 2 should be filed withir<br>f Health and Mental Hygiene.<br>Item 27 is marked other then<br>other traumatic event, the Ms | -                | 19a. Informant's Name/Relationship (7  |   | 19b. Mailir                   | ng Address                 | (Street a                             |                                |              |                                     |                    | or Town, State, Z              | ip Code)          |                         |
|            | alth a<br>27 is   |                  | W. Benton Sauter   | Husband   |                               |                            |                                       | ane B                          |              |                                     |                    | 21244                          |                   |                         |
| ore,       | of Health<br>of Health<br>litem 27  |                  | 20a. Method of Disposition   | 20b. F  | Place of Dispo                |                            |                                       |                                | Da           |                                     |                    | ocation - City or 1            | Town, State       |                         |
| Ē          | Page<br>nent<br>ant: if   |                  | 1   Burial 2 □ Cremation 3 □  Under Specify  Specify   | Heimovai itotti State   |                               |                            |                                       |                                | c. 2         | 9, 20                               | 05                 | Granite,                       | MD                |                         |
| Baltimore, | permit. Pages<br>Depertment of<br>Important: if it<br>eny injury or o   |                  | 21. Signature of Funeral Service Licens  |   |                               |                            |                                       |                                |              |                                     |                    | & Cremat                       |                   | ΡΔ                      |
| 8          | 207 2 2 9   |                  | 23y Pan. Enter the disease, or comp  | duy   |                               | 1212 1                     | W. O.                                 | ld Lib                         | erty         | Road                                | Win                | tield, N                       | D 217             | 84                      |
| 8760,      | Physician /Medical Examiner physicien end physicien end physicien end tha priai-transit   | icai Examiner    | disease or condition resulting in death)  Sequentially list conditions, france beauting to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. One to (or as a consequence to (or a) consequence to (or a) consequence to (or a) consequence to (or a) consequence to (or | uence of):<br>uence of)       |                            | reh                                   | e mes                          |              |                                     |                    |                                |                   |                         |
| 9          | artifica<br>ing ph<br>e as th   | Med              | IF FEMALE:   |   |                               |                            |                                       |                                |              |                                     |                    |                                |                   |                         |
| P.O. Box   | law requires that the death certifica<br>as been signed by the attending ph<br>2 should be delached for use as it                 | Physician/Med    | 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown   | 23c. If yes, outcome of pregna<br>1 □ Live birth 2 □ Feta<br>4 □ Pregnant at time of d<br>9 □ Unknown   | death 3                       | Ectopic pre<br>Other (spe  | egnancy<br>ecify)                     |                                |              |                                     |                    | 23d. Date of delik<br>Month    | very<br>Day       | Year                    |
|            | quires that<br>in signed b  | þ                | Part II. Other significant conditions co   | ntributing to death but not res   | ulting in the ur              | nderlying ca               | ause give                             | n in Part I.                   |              | _                                   | obacco (<br>Yes 2, | use contribute to<br>☑No 3☐Pro | the cause o       |                         |
| Records,   | The law requir<br>sate has been si<br>page 2 should I   | Completed        |  |   |                               |                            |                                       |                                | _            | 24a. Was                            | osv                | 24b. Were aut                  | opsy finding      | s available<br>cause of |
| a          | ilcian: The l<br>certificate ha<br>rector, page   |                  |  |   |                               |                            |                                       |                                |              |                                     | rmed?<br>24No      | death?                         | 22 No             |                         |
| Vital      | Physician:<br>this certific<br>al director,   | Be c             | 25. Was case referred to medical examiner?   | Hospital:   |                               |                            | Otha                                  | 26. Place of                   |              |                                     |                    |                                |                   |                         |
| ō          |   | . To             | 1 Yes 2 No 27. Manner of Death   | 1 ☐ Inpatient 2 ☐  28a. Date of Injury (Month, Day Year)  | ER/Outpatient<br>28b. Time of |                            | A Bc. Injury                          | Nursir                         |              | 5 Residuel                          |                    | 6 Other (Special               | rfy)              |                         |
| ion        | Attending Ir death.<br>actor: After<br>by the funer   | atio             | 1- Natural 5 ☐ Pending<br>2 ☐ Accident investigation   | (Month, Day Year)   | Injury                        | м                          | Work'                                 | ?<br>es 2∐No                   |              |                                     |                    | ,                              |                   |                         |
| Division   | or Attendi<br>ifter death.<br>Director: A<br>in by the fu   | Certification:   | 3 Suicide 6 Could not be<br>4 Homicide determined  | 28e. Place of Injury - At he building, etc. (Specify  | ome, farm, stre               | eet, factory,              | office                                |                                | 28           | Location (S                         | Street an          | d Number or Rui                | al Route Nu       | ımber,                  |
|            | spital cours af   |                  | 29a. Certifier 15 Certifying Phy   | sician: To the best of my kno   | wiedne death                  | occurred a                 | at the time                           | date and n                     | lace and     | d due to the                        | cauco/c)           | and monner as                  | atata d           |                         |
|            | To the Hospitei or Attenc<br>within 24 hours after deati<br>To the Funeral Director:<br>completely filled in by the               | Medicai          | one)   | iner: On the basis of examina and manner stated.  | tion and/or inv               | estigation,                | in my opi                             | nion, death o                  | occurred     | at the time,                        | date and           | place, and due                 | to the cause      | o(s)                    |
|            | To Tour   | 2                | 29b. Signature and title of certifier  |   |                               | 29c.                       | License                               | number                         |              |                                     | 29d. Dai           | te signed (Month,              | Day, Year)        |                         |
|            |   | -                | Cen glas   |   |                               |                            | 02                                    | 908                            | 2            |                                     | De                 | c 27                           | 20                | 25                      |
| 1          | ) ,   |                  | 30. Name and address of person who co  |   |                               |                            |                                       |                                |              |                                     |                    |                                |                   |                         |
|            | Sta   | te               | 31. Date filed (Month, Day, Year)  | 32. Registrar's Signa   | ture L                        | A M                        | 00                                    | CUUL                           |              | ne w                                |                    | 211                            | [.]               |                         |
|            | Registr   | ar               | DEC 2 8  | 2005 Miles  | No. V                         | The sale                   |                                       |                                |              |                                     |                    |                                |                   |                         |

Charles Scheidt

| Charles Henry Scheidt, Ir.  1. Indigital Schming    Charles Henry Scheidt, Ir.   Charles Henry Scheidt, |   |
|--|---|
| Charles Henry Scheidt, Jr.  As Payly Nate of Colorabins Green of Green of Gre | 862   |
| Funeral Director   Security Number of Consequent   Security    | Time of Death                                     |
| Director    20-14-1359   IXW 2   F 79   Yes   Months   Days   Hould   Mn.   Oly/O2/1926   Country   Ol |   |
| Discretion   Control   C   | (State or Foreign                                 |
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| Physician //Medical Examiner  Physician //Medical Physician //Medical Examiner  Physician //Medical Examiner  Physician //Medical Examiner  Physician //Medical Examiner  Physician //Medical Examiner  Physician //Medical Examiner  Physician //Medical Examiner  Physician //Medical Examiner  Physician //Medi |   |
| Physician //Medical Examiner  Physician //Medical Physician //Medical Examiner  Physician //Medical Examiner  Physician //Medical Examiner  Physician //Medical Examiner  Physician //Medical Examiner  Physician //Medical Examiner  Physician //Medical Examiner  Physician //Medical Examiner  Physician //Medi | land  |
| Physician // Medical Examiner  Physician // Medical Examiner  Physician // Medical Examiner  Physician // Medical Examiner  Physician // Medical Examiner  Physician // Medical Examiner  Physician // Medical Examiner  Physician // Medical Examiner  Physician // Medical Examiner  Physician // Medical Examiner  Physician // Medical Examiner  Physician // Medical Examiner  Physician // Medical Examiner  Physician // Medical Examiner  Physician // Medical Examiner  Physician // Medical Examiner  Physician // Medical Examiner  Physician // Medical Examiner  Sequentially ist conditions, if any, leading to immediate cause. Enter Underlying tause (libral disease or conditions, if any, leading to immediate cause. Enter Underlying tause (libral disease or conditions, if any, leading to immediate cause. Enter Underlying tause (libral disease or conditions, if any, leading to immediate cause. Enter Underlying tause (libral disease or conditions, if any, leading to immediate cause. Enter Underlying tause (libral disease or conditions, if any, leading to immediate cause. Enter Underlying tause (libral disease or conditions, if any, leading to immediate cause. Enter Underlying tause (libral disease or conditions, if any, leading to immediate cause. Enter Underlying tause (libral disease or conditions, if any, leading to immediate cause. Enter Underlying tause (libral disease or conditions, if any, leading to immediate cause. Enter Underlying tause (libral disease or conditions, if any, leading to immediate cause. Enter Underlying tause (libral disease or conditions, if any, leading to immediate cause. Enter Underlying tause (libral disease or conditions, if any, leading to immediate cause. Enter Underlying tause (libral disease or conditions, if any, leading to immediate cause. Enter Underlying tause (libral disease or conditions)  Part II. Other significant conditions contributions to death but not resulting in the underlying cause given in Part I.  Physical Examiner  Physical Examiner  Physical Examiner  Physical Examiner  P | me, P.A   |
| Due to (or as a consequence of):    Sequentially list conditions if any, leading to immediate cause. Enfort Underlying that initiated events resulting in death) Last    Due to (or as a consequence of):  | 21087<br>roximate<br>rval Between<br>et and Death |
| The part of the pa |   |
| Due to (or as a consequence of):    State   Content   Co | lans  |
| Due to (or as a consequence of):    Consider the constraint of the |   |
| The state of the s |   |
| The state of the s |   |
| The state of the s |   |
| 25. Was case referred to medical examiner?  1  | Year  |
| 25. Was case referred to medical examiner?  1  | use of death?                                     |
| 25. Was case referred to medical examiner?  1  | 4 Unknown   |
| 25. Was case referred to medical examiner?  1  | ndings available                                  |
| 25. Was case referred to medical examiner?  1  |   |
| O E E B C C Manage of Double   | 10  |
| 27. Manner of Death 1  |   |
| The state of the s |   |
| A to the fact of t |   |
| 29a. Certifier 12C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated   | 'e Number,  |
| 29a. Certifier (Check only one)  29a. Certifier (Check only one)  29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Yaka)  | ause(s)   |
| 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, You  | /ear)   |
| 12/21/05 12/21/05  |   |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)   |   |
| State  State  31. Date filed Wenth, Day, Year)  22. Registrar's Signature  |   |

Baltimore, Maryland 21215-0036

Decedent's Name (First, Middle, Last)

Summers

6. Sex

Baltimore City

15. Decedent's Education (Specify only highest grade completed)

1 ☐ M 2 ☐ F

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 🔯 No If Yes, Give Year or Dates:

College (1-4or 5+)

4a. Facility Name (If not institution, give street and number)

10b. County

Donald

Stella Maris

Usual Residence of Decedent

8011 Baltimore Street

1 Never Married 2 Married

3 Widowed 4 Divorced

Elementary/Secondary (0-12)

5. Social Security Number

245 64 2538

10e. Street and Number

Rov

10a. State

Maryland

11. Marital Status

Director

Š

**Physician** 

/Medical

Examiner

Funeral

Director

the Maryland

with

death

72 hours after

ROY

ir than "natural", or Itams 23a or 28a-f ehow the Medical Examinar must be notified at Completed Sanitation WΑ General Motors d 2 should be filed w th and Mental Hygier 7 le marked other th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 86 Virginia Spencer Unknown ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) is 1 and 2 soft Health an 8011 E Baltimore Street Baltimore, Maryland 21224 Carolyn Summers (wife) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Pages 1 permit. Pages Department of Important: If it any injury or o 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □Donation 5 □Other (Specify) Parkwood Cemetery December 27 2005 Baltimore, Maryland 22. Name and Address of Facility
Lassahn Funeral Home Inc 21. Signature of Funeral Service Licensee 7401 Belair Road 23a. Part 1. Enter the disease, or complications that saused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** PROSTATE CANCER disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, I any, Isaam y to immediate cause. Enter Underlying Cause (Disease or injury Due to for as a consequence of Examiner The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): by Physician/Medical use as the 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? iis certificate has been signed by the atten director, page 2 should be detached for u 2 Fetal death 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 2 No 1 ☐ Yes 2**X** No 1 Tes 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one) Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 NOther (Specify) HOSPICE 2 1 ☐ Yes 2 ▼ No this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After or Attending 1 XNatural
2 Accident Injury 5 Pending To the Hospitel or Attending within 24 hours after death.
To the Funeral Director: After completely filled in by the fun. 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 103 43 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093 DR. TARIQ MAHMOOD 31. Date filed (Month, Day, Year)
DEC 2 8 2005 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

7. Age (In yrs. last birthday)

10c. City, Town or Location

Baltimore

4b. City, Town, or Location of Death

If Under 1 Year | If Under 24 Hrs. 8. Date of Birth

Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

Specify:

Baltimore County

Days

10f. Zip Code

1 ☐ Yes 2 ☐ No

21224 2012

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Reg. No.

LISA

4c. County of Death

10g. Citizen of What Country?

16b. Kind of Business/Industry

14. Race - American Indian.

White

Black, White, etc.

Baltimore

December 22 2005

3. Time of Death

9:25 P

10d. Inside City Limits

1 ☐ Yes 2 ☐ No

9. Birthplace (State or Foreign

Franklin, West Va

2. Date of Death

April 2 1940

CPM 05-08709 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Unpend item#23a,27,perME,1852,2/1/06TT State of Maryland / Department of Health and Mental Hygiene Mignon Sears For State Registrar Reg. No. UU5 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** December 24, 2005 11:15 Mignon Lynn Sears /Medical 4a. Facility Name (If not institution, give street and number) 4b. Cilv. Town, or Location of Death 4c. County of Death Examiner 4500 Old National Pike Carroll Airy If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 ☐ M 2 反 F 230-86-6607 Yrs. 41 Director June 13,1964 VA Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits or 28a-f ehow the Medical Examinar must be notified at 1 ☐ Yes 2 ☐ No Director SC Berkley Ladson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 29456 9494 Hwy 78 E6 United States itema 23a Completed by Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 277No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married ō Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ◯XNo Specify: Specify. White 3 Widowed 4 Trivorced 'naturel' 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Administrative assitant The Aflery group . Pages 1 and 2 should be filed v tment of Health and Mental Hygie tant: if Item 27 is marked other t jury or other traumatic event, III 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Raymond Aubrev Sears Pamelyn Kline Berry 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20886 19a. Informant's Name/Relationship (Type, Print) 19811 Greenside Terrace Montgomery Village, MD Sonny Eustace son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department o Important: If any injury or once. South Carroll Crematory Dec. 26, 2005 Winfield, MD 4 □ Donation 5 □ Other (Specify) <sup>22.</sup> Name and Address of Facility
Burrier-Queen Funeral Home & Crematory, PA
1212 W. Old Liberty Road Winfield, MD 21784 21. Signature of Funeral Service Licenses 23a. P.nt. E ter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shick, in heart failure. List only one cause on each line. Cardiac Arrhythmia associated with Cocaine use and Immedia e ause (Final disease v ondition resulting in death) Atherosclerotic Cardiovascular Disease Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) physicien and the burial-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, Completed by Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 3 ☐ Ectopic pregnancy 0 Month Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the at d be detached for of Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of eath?

1 Yes 2 No 24a. Was an autopsy performed? 1 Yes 2 No To Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 NOther (Specify) SCENE 1X Yes 2 □ No his tor: After this the funeral of 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Medical Certification: 28b. Time of 28d. Describe how injury occurred Division 5 Pending investigation To the Hospital or Attendin within 24 hours after death.
To the Funeral Director: Att completely filled in by the fun 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number Whente O.C.M.E. December 25, 2005 who completed cause of death (Item 23a) (Type, Print) ALLAMON KOREL 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year) DEC 2 8 2005 32 Registrar's Signature

| Examine  | No.   |
|--|---|
| Aviedical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death  | 3. Time of Death  |
| Examiner  4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death   | 21, 2005 8:50 P M   |
| Couthorn Morniland Hagnital Contar Clinton   | 4c. County of Death   |
| Southern Maryland Hospital Center Clinton  | Prince George's   |
| Funeral 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, Year   | 9. Birthplace (State or Foreign Country)  |
| Director 527 29 4462 X X 20 40 Yrs.   Sept 30,10   | 965 Michigan  |
| Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location  | 10d. Inside City Limits   |
| New Jersey Hudson Weehawken Clinton  | 1 X Yes 2 No  |
| Maryland Prince George Clinton  10e. Street and Number 261 Park Avenue Apt 3  4000 Street and Sumber 261 Park Avenue Apt 3   | Citizen of What Country?  |
| The part of the pa | United States   |
| 11. Marital Status    Status   12. Was Decedent Ever in U.S.   13. Was Decedent of Hispanic Origin? (Specify Yes or No-lif Yes, specify Cuban, Mexican, Puerto Rican, etc.)    Status   12. Was Decedent Ever in U.S.   13. Was Decedent of Hispanic Origin? (Specify Yes or No-lif Yes, specify Cuban, Mexican, Puerto Rican, etc.)   | 14. Race - American Indian,   |
| Armed Forces?  If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  XX Never Married 2 Married 1 Yes YZY No II Yes Griden.  If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  | Black, White, etc.  |
| If Yes, Give ↑ 1 ☐ Yes 2☐ No Specify: Year or Dates:   | Specify: Black  |
| 15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)  16b. College (1-4or 5+) 12  16b. Make Up Artist  | . Kind of Business/Industry   |
| (Specify only highest grade completed)  (Give kind of work done during most of working life. DO NOT use retired)   |   |
| N 8 8 8 12 6 Make Up Artist  | Self Employed   |
| 17. Father's Name (First, Middle, Last)  18. Mother's Name (First, Middle, Maide, Maide)   | den Sumame)   |
| Herman W. Spearman Lillian McNeil  |   |
| Secondary   Seco   | ty or Town, State, Zip Code) 20735  |
| 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c.  | Location - City or Town, State  |
| 20a. Mathod of Disposition  20b. Place of Disposition (Name of cemetery, crematory or other place)  20c. Place of Disposition (Name of cemetery, crematory or other place)  20c. Place of Disposition (Name of cemetery, crematory or other place)  20c. Place of Disposition (Name of cemetery, crematory or other place)  20c. Place of Disposition (Name of cemetery)  20c. Place of Disposition (Name of cemetery)  20c. Place of Disposition (Name of cemetery)  21. Signature of Funeral Service Licensee  22. Name and Address of Facility Lee Funeral I  | inton, Maryland   |
| 4 Donation 5 Other (Specify)  Resurrection Cemetery  21. Signature of Funeral Service Licensee  22. Name and Address of Facility Log Funeral 1   |   |
| Herman W. Spearman (Father) 4900 Sweden Court, Clinton, MD  20a. Mathod of Disposition  20b. Place of Disposition (Name of cemestery, crematory or other place)  20c. Clinton  20c. Place of Disposition (Name of cemestery, crematory or other place)  20c. Resurrection Cemetery  21. Signature of Funeral Stocke Licensee  22. Name and Address of Facility Lee Funeral Facility Lee Funeral Facility Lee Funeral Facility Lee Funeral Facility Lee Funeral Facility Lee Funeral Facility Lee Funeral Facility Lee Funeral Facility Lee Funeral Facility Lee Funeral Facility Lee Funeral Facility Facili |   |
| 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.   | Approximate<br>Interval Between   |
| Physician Immediate Cause (Final disease or condition as Cere B10 Vasca Disease Physician death)   | Onset and Death   |
| /Medical resulting in death)  Due to (or as a consequence of):   | year  |
| Examiner  Sequentially list conditions,  b   |   |
| but fany, leading to immediate Due to (or as a consequence of):  |   |
| that initiated events that initiated events resulting in death) Last  Due to (or as a consequence of):   |   |
| po to least of the control of the co |   |
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| physicial physicial diffical  difficult  |   |
| SO THE STATE | 22d Date of deliver   |
| The factor of th | 23d. Date of delivery<br>Month Day Year   |
| The first part of the policy o |   |
| FFEMALE: 23b. Was decedent pregnant in the past 12 months?   1   |   |
| FFEMALE: 23b. Was decedent pregnant in the past 12 months?   1   | Month Day Year  co use contribute to the cause of death?  |
| FFEMALE: 23b. Was decedent pregnant in the past 12 months? 1   | Month Day Year  ouse contribute to the cause of death?  2 No 3 Probably 4 Unknown   |
| FFEMALE: 23b. Was decedent pregnant in the past 12 months? 1   | Month Day Year  co use contribute to the cause of death?  2 No 3 Probably 4 Unknown  24b. Were autopsy findings available prior to completion of cause of death?  |
| FFEMALE: 23b. Was decedent pregnant in the past 12 months? 1   | Month Day Year  co use contribute to the cause of death?  2 No 3 Probably 4 Unknown  24b. Were autopsy findings available prior to completion of cause of death?  |
| FFEMALE: 23b. Was decedent pregnant in the past 12 months? 1   | Month Day Year  ouse contribute to the cause of death?  2 No 3 Probably 4 Unknown  24b. Were autopsy findings available prior to completion of cause of death?  1 Yes 2 No  |
| FFEMALE: 23b. Was decedent pregnant in the past 12 months? 1   | Month Day Year  co use contribute to the cause of death?  2 No 3 Probably 4 Unknown  24b. Were autopsy findings available prior to completion of cause of death?  1 Yes 2 No  6 Other (Specify)   |
| FFEMALE:   23c. If yes, outcome of pregnancy   1   | Month Day Year  co use contribute to the cause of death?  2 No 3 Probably 4 Unknown  24b. Were autopsy findings available prior to completion of cause of death?  1 Yes 2 No  6 Other (Specify)   |
| FFEMALE:   23c. If yes, outcome of pregnancy   1   | Month Day Year  co use contribute to the cause of death?  2 No 3 Probably 4 Unknown  24b. Were autopsy findings available prior to completion of cause of death?  17 No 1 Yes 2 No  6 Other (Specify)  Injury occurred  |
| FFEMALE:   23c. If yes, outcome of pregnancy   1   | Month Day Year  co use contribute to the cause of death?  2 No 3 Probably 4 Unknown  24b. Were autopsy findings available prior to completion of cause of death?  17 No 1 Yes 2 No  6 Other (Specify)  Injury occurred  |
| FFEMALE:   23c. If yes, outcome of pregnancy   1   | Month Day Year  Ouse contribute to the cause of death?  2 No 3 Probably 4 Munknown  24b. Were autopsy findings available prior to completion of cause of death?  1 Yes 2 No  6 Other (Specify)  Injury occurred  It and Number or Rural Route Number, late)   |
| FFEMALE:   23c. If yes, outcome of pregnancy   1   | Month Day Year  To use contribute to the cause of death?  2 No 3 Probably 4 Unknown  24b. Were autopsy findings available prior to completion of cause of death?  1 Yes 2 No  6 Other (Specify)  Injury occurred  Trand Number or Rural Route Number, lare)  1 and number or Rural Route Number, lare)  1 and manner as stated.  2 and place, and due to the cause(s)  Date signed (Month, Day, Year) |
| IF FEMALE: 23b. Was decedent pregnant in the past 12 months?   1   Yes 2   No 9   Unknown   9   Unknown   9   Unknown   9   Unknown   1   Yes 2   No 9   Unknown   9   Unknown   9   Unknown   1   Yes 2   No 9   Unknown   1   Yes 2   No 9   Unknown   1   Yes 2   No 9   Unknown   1   Yes 2   No 9   Unknown   1   Yes 2   No 9   Unknown   1   Yes 2   No 9   Unknown   25. Was case referred to medical examiner?   1   Yes 2   No   Hospital:   Inpatient 2   EP/Outpatient 3   DOA   Other:   Anursing Home 5   Residence   28a. Date of Injury.   Month, Day Year)   Injury   Month, Day Year)   Injury   Month, Day Year)   1   Yes 2   No   28b. Place of Injury. At home, farm, street, factory, office   28f. Location (Street City or Town, State and manner stated.   29b. Signature and title of certifier   29b. Signature and title of certifier   29b. Cicense number   29d. Division   2   | Month Day Year  to use contribute to the cause of death?  2 No 3 Probably 4 Unknown  24b. Were autopsy findings available prior to completion of cause of death?  1 Pes 2 No  6 Other (Specify)  Injury occurred  t and Number or Rural Route Number, late)  e(s) and manner as stated. and place, and due to the cause(s)  |
| FFEMALE:   23b. Was decedent pregnant in the past 12 months?   1   | Month Day Year  Do use contribute to the cause of death?  Day Year  Do use contribute to the cause of death?  Day Year  Do use contribute to the cause of death?  Day Year  Dunknown  24b. Were autopsy findings available prior to completion of cause of death?  1  |
| FFEMALE:   23c. If yes, outcome of pregnancy   1   1   1   1   1   1   1   1   1   | Month Day Year  Do use contribute to the cause of death?  Day Year  Do use contribute to the cause of death?  Day Year  Do use contribute to the cause of death?  Day Year  Dunknown  24b. Were autopsy findings available prior to completion of cause of death?  1  |

State Registrar

DEC 2 8 2005

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

31. Date filed (Month, bay, Year)



29c. License number

OCME

29d. Date signed (Month, Day, Year)

DECEMBER 26, 2005

|                     |  | •              | For<br>Stata<br>Registrar   | State of Mary                               | •                                | artment of H                                |   |                                   | jiene<br>•92005      | 41867   |
|---------------------|--|----------------|---|---|----------------------------------|---|---|-----------------------------------|----------------------|---|
|                     |  |                | Decedent's Name (First, Middle, Last)   |   |                                  |   |   | 2. Date of Dear                   | th<br>Day Ye         | 3. Time of Death  |
|                     | Physicia<br>/Medic   |                | Ervin S. Smith J  | <u> </u>                                    |                                  |   |   | Decembe                           | r 21, 200            | 05 11:18 AM <sup>M</sup>                                      |
|                     | Examin   |                | 4a. Facility Name (If not institution, give s   | treet and number)                           |                                  | 4b. City, Town, or                          | Location of Deatl                       | 1                                 | 4c. County of D      |   |
|                     |  |                | Gilchrist Hospice 5. Social Security Number 6. Sex  |   | n yrs. last birthday)            | Towso                                       | n<br>If Under 24 Hrs.                   | 8. Date of Birth                  | Baltimo              |   |
|                     | Funeral Director   |                | 1 ☑   | M 2DE                                       | Yrs. Yrs.                        | Months Days                                 | Hours Min.                              | May 25,                           |                      | Birthplace (State or Foreign<br>Country)<br>irginia           |
|                     |  |                | 219-03-8438 A Usual Residence of Decedent   |   |                                  |   |   | may 25                            | 1920   V             | IIgIIIIa  |
|                     | how  |                | 10a. Stale 10b. County  | 10  | c. City, Town or Lo              | ocation                                     |   |                                   |                      | 10d. Inside City Limits                                       |
|                     | Ba-f e   | Director       | MD Baltimo  | re  | Towso                            |   |   |                                   |                      | 1 ☐ Yes 2 ☐ No  |
|                     | with th  | 吉              | 10e. Street and Number 6601 N. Charles S  | + woo +                                     |                                  | 10f. Zip Code                               | 204                                     | 1                                 | Og. Citizen of Wha   | Country?  |
|                     | hours after death with the Maryland<br>turel', or iteme 23s or 28s-f ehow<br>I Exeminer must be mailfied at  | Funeral        |   | 2. Was Decedent Eve                         | rin II S 13                      |   |   | necity Yes or No.                 | USA<br>14 Bace : A   | lmerican Indian.  |
|                     | iter de  | J.             | 11. Marital Status  1 ☐ Never Married 2 ☑ Married   | Armed Forces? 1 ☐Yes 2 ☐ No If Yes, Give    | 111 0.3.                         | Was Decedent of Hi<br>If Yes, specify Cuba  | n, Mexican, Puert                       | o Rican, etc.)                    |                      | Vhite, etc.   |
| 036                 | of, o  | þ              | 3 Widowed 4 Divorced  | If Yes, Give<br>Year or Dates: 14           | 2-45                             | 1 ☐ Yes 2 ☑ No                              | Specify:                                |                                   | Specify:             | white   |
| 5-0                 | CI BE US   | Completed      | 15. Decedent's Educ<br>(Specify only highest grade  | ation                                       | 16a. Dece                        | dent's Usual Occupa<br>kind of work done of |   | kina                              | 16b. Kind of Busine  | ess/Industry  |
| 21                  | f within 7,<br>iene.<br>r then "n  | d d            | Elementary/Secondary (0-12)   | College (1-4or 5+)                          | life.                            | DO NOT use retired,                         | )                                       |                                   |                      |   |
| 2                   |  |                | 12<br>17. Father's Name (First, Middle, Last)   | 5   | ac                               | countant                                    | 18 Molher's Nac                         | ne (First, Middle, i              | financi:             | 11  |
| Maryland 21215-0036 | be de la paragraphica de la para | Be.            | Ervin Sylvester   | Cmith                                       |                                  |   |   |                                   | naiden demame,       |   |
| 7                   | d 2 should it<br>th and Meni<br>7 is marke<br>traumatic  | Ç              | 19a. Informant's Name/Relationship (Typ   |   | 19b. Maili                       | ng Address (Street a                        | Ada Waş                                 |                                   | , City or Town, Star | re, Zip Code)   |
|                     | ar 7   |                | Mary Smith/spouse   |   | 413                              | Brook Roa                                   | d Towson                                | , MD 21                           | 286                  |   |
| re,                 | - I  |                | 20a. Method of Disposition  |   | 20b. Place of Dispo              | sition (Name of<br>matory or other place    | 9)                                      | Date                              | 20c. Location - City | or Town, State  |
| m                   | Pages<br>nent of I<br>int: if it   |                | 1 ☐ Burial 2 ☐ Cremation 3 ☐ Re<br>4 ☑ Donation 5 ☐ Other (Specify)   | emoval from State                           | ,,                               | ,   | 1                                       |                                   |                      |   |
| Baltimore,          | permit. Page<br>Department<br>Important: if<br>eny injury or<br>once.  |                | 21. agasture of Funeral Servic License Ronald S. W  | ade, vizec                                  | tor Si                           | 2. Name and Addres                          | omy Boar                                |                                   | Baltimor             | e Street  |
|                     | *  |                | 23a. Part1. Enter the disease, or complice  | ations that caused the                      |                                  | altimore,<br>er the mode of dying           |   |                                   | est,                 | Approximate<br>Interval Belween                               |
|                     | Physician  |                | shack, or heart failure. List only on<br>Immediate Cause (Final<br>disease or condition                     | Cause of each infe                          | 1,000                            | 3-0000                                      | 1 Lun                                   | ohoma                             | 1                    | Onset and Death   |
| 1                   | /Medical   |                | resulting in death)   | Due to (or as a co                          | onsequence of):                  | <u> </u>                                    |   |                                   | 7                    | 770070  |
| ž                   | Examiner   |                | Sequentially list conditions.   |   |                                  |   |   |                                   |                      |   |
|                     | od sit   | lue            | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | Due to (or as a co                          | onsequence of):                  |   |   |                                   |                      |   |
|                     | xecut<br>and<br>il-tran  | Examine        | that initiated events c. resulting in death) Last   | Due to (or as a co                          | onsequence of):                  |   |   |                                   |                      |   |
| 8760,               | The law requires that the death certificate be executed to has been signed by the attending physicien and bage 2 should be detached for use as the burral-transit  | dical E        | L.  |   |                                  |   |   |                                   |                      |   |
| 687                 | ificate<br>g phys<br>as the  | edic           |   |   |                                  |   |   |                                   |                      |   |
| Вох                 | eath certific<br>attending p   | Z              | IF FEMALE: 23b. Was decedent pregnant 23  | 3c. If yes, outcome of p                    |                                  | Ectopic pregnancy                           |   |                                   | 23d. Date of         | delivery  |
|                     | deat   | Physician/Me   | in the past 12 months?<br>1 ☐ Yes 2 ☐ No  | 4☐Pregnant at tim                           |                                  | Other (specify)                             | ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, |                                   | Month                | Day Year  |
| P.0                 | at the de<br>d by the a<br>etached   | Phy            | 9 Unknown   |   |                                  |   |   |                                   |                      |   |
|                     | ires thai<br>signed b  | by             | Part If. Other significant conditions con   | 1. 0.                                       | ot resulting in line u<br>U CCR  | nderlying cause give                        | n in Part.                              | 23e. Did to                       |                      | e to the cause of death?  ] Probably 4Unknown                 |
| 9                   | w requir<br>been si<br>should  | Completed      | 7   | 0-111 6 60                                  | MC CK                            |   |   | -                                 | /-                   |   |
| 3ec                 | e law<br>has t   | du             |   |   |                                  |   |   | 24a. Was a autops perform         | sy prior             | autopsy findings available<br>to completion of cause of<br>n? |
| a                   |  | e Co           | 05 144  |   |                                  |   |   | 1 Yes                             | 20 No 10             | Yes 2□No  |
| of Vital Records,   | sicia<br>cer<br>rect   | To Be          | 25. Was case referred to medical examiner?  1 ☐ Yes 2 ☒ No  | ospital:                                    | 2 ER/Outpatier                   | nt 3 DOA Othe                               | ar                                      | th (Check only on                 | ence 6 COther (      | Specify) HOSPICE  |
| o                   | g Phys<br>er this<br>eral di   |                | 27. Manner of Death   | 28a. Date of Injury<br>(Month, Day Ye       | 28b. Time o                      |   |   |                                   | ow injury occurred   | ppacity) ( 8227 Q   |
| ion                 | ttending I<br>death.<br>ctor: After<br>y the funer   | atlo           | 1 Natural 5 ☐ Pending<br>2 ☐ Accident investigation   | (WORLI, Day 16                              | ear) Injury                      |   | Yes 2 □ No                              |                                   |                      |   |
| Division            | for Attence after death Director:  | Certification: | 3 Suicide 6 Could not be determined   | 28e. Place of Injury<br>building, etc. (\$  | - At home, farm, sti<br>Specify) | reet, factory, office                       |   | 28f. Location (Si<br>City or Town |                      | r Rural Route Number,   |
|                     | To the Hospitel or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the fune   |                | 29a. Certifier 1 1 Certifying Phys  | ician: To the best of m                     | av knowledge des                 | h occurred at the time                      | e date and place                        | and due to the o                  | ausals) and mass     | r as stated   |
|                     | • Hos<br>24 hi<br>• Fun<br>etely   | edical         | (Check only 2 Medical Examin  | ar: On the basis of ex<br>and manner stated | amination and/or in              | vestigation, in my or                       | pinion, death occu                      | rred at the time, d               | ate and place, and   | due to the cause(s)   |
|                     | within<br>To the   | Me             | 29b. Signature and little of certifier  | 1 = 17                                      |                                  | 29c. License                                | number                                  |                                   | 9d. Date signed (M   | •   |
|                     |  |                | > If Hother   | , thele                                     | no                               | 00  | 45205                                   |                                   | Keemb                | er 21,2005  |
|                     |  |                | 30. Name and address of person who co   | mpleted cause of deat                       | h (Item 23a) (Type,              | Print)                                      | 2 0 0                                   |                                   |                      |   |
|                     |  |                | W.H.R.L   | 7 691                                       |                                  | 1 N.Ch                                      | nels J                                  | 7. Balt                           | 1. Md >              | 120%  |
|                     | Sta<br>Registr   |                | 31. Date filed (Month, Day, Year)  DFC 2. 8. 201  | 32. Registrar's                             | Signature                        | all!  |   |                                   |                      |   |

|              |  |                 |  |   | l / Depa                               | ırtme                            | nt of Health a<br>te of Death                                      |                           | ental Hygi   |                                    | ie.  | 1868   |
|--------------|--|-----------------|--|---|--|----------------------------------|--|---------------------------|--|------------------------------------|--|--|
| *            | Physici  | ian             | Decedent's Name (First, Middle, Last)  | ce Esther   | Stone                                  | Δ                                |  |                           | 2. Date of Death<br>Month                          | Day                                | Year                                       | 3. Time of Death   |
|              | /Medic<br>Examir   |                 | 4a. Facility Name (If not institution, give street and n   |   |  | 4b. Cit                          | y, Town, or Location of  | of Death                  | <u>Decembe</u><br>tu                               | 4c. County o                       | COS<br>of Death<br>Baltimo                 | <i>81.</i> 79 ₱ м<br>re City                             |
|              | Funeral<br>Director  |                 | 5. Social Security Number 6. Sex 1 ☐ M 2 ☐ F   | 7. Age (In yrs. las   | st birthday)<br>Yrs.                   |                                  | er 1 Year If Under   |                           | 8. Date of Birth<br>(Month, Day,<br>March 21,      |                                    |  | ace (State or Foreign<br>ry)<br>w Jersey                 |
|              | Maryland<br>a-f ehow   | tor             | Usual Residence of Decedent  10a. State  10b. County  Maryland  Howard   | 10c. City,  | Town or Los                            | cation                           | Columbia   | a                         |  |                                    | 10   | d. Inside City Limits                                    |
|              | 3a or 28   | i Director      | 10e. Street and Number<br>6500 Freetown Rd.  |   |  | 10f. Z                           | ip Code<br><b>21</b> 0   | )44                       | 10   | g. Citizen of W                    | hat Count<br>U.S.A                         | *  |
| 036          | be filed within 72 hours after death with the Maryland stal Hygiene.  Id other than "natural", or Items 23a or 28s-f show event, the Medical Exartinar must be notified at | by Funeral      | 11. Marital Status 12. Was De<br>Armed F   | 2 No<br>live  |  |                                  | edent of Hispanic Oriectly Cuban, Mexican                          | gin? (Spec<br>n, Puerto A | offy Yes or No-<br>lican, etc.)                    | 14. Race<br>Black<br>Specify:      | , White, e                                 | in Indian,<br>tc.<br>Vhite                               |
| 21215-0036   | within 72 ho<br>piene.<br>r than "natur<br>the Medical i   | Be Completed    | 15. Decedent's Education (Specify only highest grade completed  Elementary/Secondary (0-12)  College                 | (1-4or 5+)  | 16a. Deced<br>(Give I<br>life. L       | lent's Us<br>kind of w<br>DO NOT | ual Occupation<br>york done during most<br>use retired)<br>unknown |                           | g 1  | 6b. Kind of Bus                    | iness/Indi                                 | *  |
| yland        | should be filed<br>nd Mental Hyg<br>merked othe<br>imatic event,   | To Be C         | 17. Father's Name (First, Middle, Last) Otto Sternfeld   |   |  |                                  | 18. Mothe  | er's Name                 | (First, Middle, M<br>Rach                          | aiden Sumame<br>el Rosenti         |  |  |
| Mar          | and 2 sh<br>salth and<br>n 27 is m   |                 | 19a. Informant's Name/Relationship (Type, Print)   | Nephew  |  | -                                | ss <i>(Street</i> an <i>d Numbe</i><br>Ivy Bush Lane               |                           |  |                                    | itate, Zip (                               | Code)  |
| saltimore,   | nit. Pages 1 and 2 should<br>artment of Health and Mer<br>ortent: if item 27 is marke<br>injury or other traumatic   |                 | 20a. Method of Disposition  1 Burial 2 Coremation 3 Removal from 4 Donation 5 Other (Specify)                        | 20b. Pla  | -                                      | natory or                        | ame of other place)  |                           | 1/2005   | 0c. Location - C                   | ity or Tov                                 |  |
| Dall         | permit. Departr Importe any inj  |                 | 21. Signal re of Funeral Service Licensee  | 100575  | 22.                                    | . Name :                         | and Address of Facility<br>Slack Funeral<br>3871 Old Colu          | Home,                     | P.A.   | City MD 2                          | 1043                                       |  |
| )· .         | Physician<br>/Medical<br>Examiner  |                 |  | ulmono<br>o (or as a conseque<br>on qesti                             | ary (                                  | 0                                | ode of dying, such as  |                           | respiratory arre                                   |                                    |  | Approximate Interval Between Onset and Death Aay 5 46015 |
| 68/60,       | es that the death certificate be executed igned by the attending physician and be detached for use as the burial-transit   | edical Examiner | cause. Enter Underlying Cause (Disease or injury that initiated events  c.   | o (or as & conseque   |  |                                  |  |                           |  |                                    |  |  |
| O. Box o     | the death certifica<br>y the attending ph<br>iched for use as th   | Physician/Me    | in the past 12 months?   | utcome of pregnand<br>birth 2 Tetal d<br>gnant at time of dea<br>nown | leath 3 🗌                              |                                  | pregnancy<br>specify)  |                           |  | 23d. Date<br>Mont                  |  | y<br>Day Year  |
| ras, r       | The law requires that the tee bas been signed by the bage 2 should be detache  | by              | Part II. Other significant conditions contributing to  |   | ting in the un                         | nderlying                        | cause given in Part I.   |                           | 23e. Did toba                                      |                                    |  | cause of death?  |
| al Records   |  | Completed       | anemia   |   |  |                                  |  |                           | 24a. Was an autopsy perform                        | pr                                 | ere autopo<br>lor to com<br>lath?<br>Yes 2 | sy findings available pletion of cause of                |
| ion of vital | this<br>rald   | ation: To Be    | 27. Manner of Death 28a. Date  |   | R/Outpatient<br>28b. Time of<br>Injury | 3 🗆 C                            | Othor  | rsing Hom                 | (Check only one<br>e 5 Resider<br>3d. Describe how | nce 6 Other                        |  | 4.18   |
| DIVISION     | To the Hospital or Attending within 24 hours after death.  To the Funerel Director: After completely filled in by the funer  | Certification:  | 3 Suicide 6 Could not be 28e. Place  | ce of Injury - At hom<br>ding, etc. (Specify)                         | ne, farm, stre                         | eet, facto                       | ory, office  | 21                        | Bf. Location (Stre<br>City or Town,                |                                    | or Rural                                   | Route Number,  |
|              | ne Hospii<br>n 24 hour<br>ne Funeri  | edical          | 29a. Certifier (Check only one) 1 Greatifying Physician: To the 2 Medical Examiner: On the and ma                    | ne best of my knowl<br>basis of examinatio<br>nner stated.            | ledge, death<br>on and/or inv          | occurre                          | d at the time, date an<br>in, in my opinion, deat                  | d place, ar<br>th occurre | nd due to the cau<br>d at the time, dat            | use(s) and man<br>te and place, ar | ner as sta<br>nd due to t                  | ted.<br>he cause(s)                                      |
| )            | To the To the Comp   | W               | 29b. Signature and little of certifier   | No  | )                                      | -                                | RE'S - 0   | $\infty$                  |  | d. Date signed<br>Pecembe          | -  | ay. Year)  |
|              | 7  |                 | 30. Name and address of person who completed cau  Erika Olander  | use of death (Item 2  | 23a) (Type, F                          | Print)                           | spital or  | e.B.                      | altimi   |                                    |  | •  |
|              | Sta<br>Registr   |                 | 30. Name and address of person who completed cau  Erika Olander  31. Date filed (Month, Day, Year) 32.  DEC 2 8 2005 | Registrar's Signatu   | re                                     | and                              | 2  |                           |  |                                    |  |  |

|  |                  | 1 - For<br>State<br>Registrar   | State of Marylai   | •                           | artmen<br>rtificat                   |                          |                                   |                         |                                 | giene<br>100 15                                   | 41869  |
|--|------------------|---|--|-----------------------------|--------------------------------------|--------------------------|-----------------------------------|-------------------------|---------------------------------|---|--|
| Physic   | ian              | Decedent's Name (First, Middle, Last)   | rothy L. Crate   | Stonn                       | iello                                |                          |                                   |                         | 2. Date of Dea<br>Month         | Day Year  | 3. Time of Death<br>7:50 a.                        |
| /Medi<br>Examii  |                  | 4a. Facility Name (If not institution, give   | street and number)   | , оторр                     |                                      | Town, or                 | Location                          |                         |                                 | mber 26, 2005<br>4c. County of De                 | ath  |
| Funeral<br>Director  |                  | 5. Social Security Number 6. Sex  | IM aXIF  | . last birthday)            | If Under<br>Months                   | 1 Year<br>Days           | If Under<br>Hours                 | Colu<br>24 Hrs.<br>Min. | 8. Date of Birth<br>(Month, Day | 9. B  | Howard<br>irthplace (State or Forei<br>Country)    |
| ם י  | tor              | Usual Residence of Decedent  10a. State 10b. County   |  | ity, Town or Lo             | ocation                              |                          | olumbi                            | 2                       | October 3                       | 3, 1927   | New Jersey  10d. Inside City Limi  1 □ Yes 220     |
| with the   | Director         | 10e. Street and Number  | waru   |                             | 10f. Zip                             |                          |                                   | 044                     |                                 | 10g. Citizen of What (                            |  |
| ed within 72 hours after death with the Maryland<br>Ygiene.<br>ier then "natural", or iteme 23e or 28e-f ehow<br>i, the Medical Experient fram the modified at | by Funeral       | 6267 Golden Hook  11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced                          | 12. Was Decedent Ever in I<br>Armed Forces?<br>1 Yes 2 No<br>If Yes, Give<br>Year or Dates:      |                             | Was Dece<br>If Yes, spe              |                          |                                   |                         | cify Yes or No-<br>lican, etc.) |   | .S.A.<br>nerican Indian,<br>nite, etc.<br>White    |
| d within<br>giene.<br>rr then  | Completed        | 15. Decedent's Edu<br>(Specify only highest grad<br>Elementary/Secondary (0-12)                               | cation<br>e completed)<br>College (1-4or 5+)   | 16a. Dece<br>(Give<br>life. | dent's Usu<br>kind of wo<br>DO NOT u | erk doné d<br>se retired | ation<br>furing mos<br>)<br>nemak | t of workin             | g                               | 16b. Kind of Busines                              | s/Industry<br>rn Home                              |
| be first H dot   | To Be (          | 17. Father's Name (First, Middle, Last)  George Ri  19a. Informant's Name/Relationship (Ty                    | chard Crate  | 19b. Mailir                 | na Address                           | (Street                  |                                   |                         | Ida                             | Maiden Sumame)  Mae Currey r, City or Town, State | . Zip Code)  |
|  |                  | Mrs. Irene Babish  20a. Method of Disposition  1 Burial 2 Cremation 3 F                                       |  |                             | 3267 Go                              | olden H                  | look C                            |                         | , Marylan                       |   |  |
| permit. Pages 1 a Department of He- Important: If item eny injury or othe  |                  | 4 Donation 5 Other (Specify)  21. Signature of Funeral Source Lice is  23a. Part1 rihe, dis-rate, or complete | D WO!  | 2-1-                        | 2. Name ar                           | nd Addres                | s of Facili                       | ty                      | 9/2005 <u> </u>                 |   | le, Maryland                                       |
| Physician<br>/Medical<br>Examiner  | er               | snock, or near failure List only of<br>Immediate Cause (Final<br>disease or condition<br>resulting in death)  | Due to (or as a conse  | quence of):                 | valve                                |                          | disco                             |                         | ( 4                             | 2 4 . 1 )   | Approximate<br>Interval Between<br>Onset and Death |
| ficate be executed<br>physician and<br>is the burial-transit   | edicai Examiner  | cause. Enter Underlying Cause, (Disease or injury that initiated events resulting in death) Last              | Due to (or as a conse  | cw dic                      |                                      |                          | cover                             |                         | ( 41                            | ( 429-2)<br>( 429-2)                              |  |
| at the death certificate<br>by the attending phys<br>tached for use as the   | Physician/M      | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown                       | 3c. If yes, outcome of pregr<br>1 ☐ Live birth 2 ☐ Fet<br>4 ☐ Pregnant at time of<br>9 ☐ Unknown | tal death 3[                | ⊒Ectopic p<br>⊒ Other (sµ            |                          |                                   |                         |                                 | 23d. Date of d<br>Month                           | elivery<br>Day Year                                |
| The law requires that the<br>tte has been signed by the<br>page 2 should be detache  | ompleted by P    | Part II. Other significant conditions con   | ntributing to death but not re   | _                           | nderlying d                          | cause give               | en in Part I                      |                         |                                 | es 2 11/No 3 1                                    | to the cause of death?  Probably 4 Unkno           |
|  | Ве Сотрі         | 25. Was case referred to medical examiner?  |  |                             |                                      |                          | 26. Place                         | e of Death              | autop:<br>perfor<br>1 Yes       | sy prior to<br>med? death?<br>2 ☑ No 1 ☐ Ye       | completion of cause                                |
| ng Phy:<br>fler this<br>neral d  | ၉                | 1 Yes 2 No F  | Hospital: 1 ☐ Inpatient 2 ☐ 28a. Date of Injury (Month, Day Year)                                | 28b. Time o                 |                                      | 28c. Injun<br>Worl       | 4   N                             | 28                      |                                 | ence 6 Other (Sp<br>ow injury occurred            | ecify)   |
|  | i Certification: | 3 Suicide 6 Could not be determined   | 28e. Place of Injury - At building, etc. (Spec   | eify)                       |                                      |                          | a dat -                           |                         | City or Tow                     |   |  |
| To the Hospital or<br>within 24 hours afte<br>To the Funeral Dir<br>completely filled in   | Medical          | (Check only 2 Medical Exami   | sician: To the best of my kr<br>ner: On the basis of examin<br>and manner stated.                | nation and/or in            | vestigation                          | n, in my o               | oinion, dea                       | id place, at            | d at the time, o                | date and place, and de                            | ue to the cause(s)                                 |
| T will   | -                | 29b. Signature and title of certifier   | ~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~   | 02                          |                                      | c. Licens                | 441                               | 83                      |                                 | 12/28/63  | om, Day, Year)                                     |
| St<br>Regist   | ate              | 30. Name and address of person who co   | BENST NAT  | L D.                        | Print)                               | <b>5</b> 4:              | Sc j                              | Cucil                   | North                           | Drive,  | 2104   |

| • 4                            |   |                                     | 1 - State Registrar  1. Decedent's Name (First, Middle, La.)   | State of Marylan  |   | nt of Health and<br>te of Death  | Reg   | ene 05  | 41870   |
|--------------------------------|---|-------------------------------------|--|---|---|--|---|---|---|
|                                | Physic<br>/Med<br>Exami<br>Funeral<br>Director  | cal<br>ner                          | 4a. Facility Name (If not institution, give  | e street and number)  TO II  PX  T. Age (In yrs. I  |   | y. Town, or Location of De<br>Left Year If Under 24 His Days Hours Mi  | S. 8. Date of Birth   |   | ath  Chiplace (State or Foreign country)  Tennsylvania  |
| Baltimore, Maryland 21215-0036 | permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "naturel", or Items 23a or 28a-f show any nijury or other traumatic event, the Medical Examiner must be notified at once. | To Be Completed by Funeral Director | 10a. State 10b. County  Maryland H  10e. Street and Number  6336 Cedar Lane  11. Marital Status  1 □ Never Married 2 □ Marned  3 ₩ Widowed 4 □ Divorced  15. Decedent's Ec (Specify only highest grave)  Elementary/Secondary (0·12)  unk  17. Father's Name (First, Middle, Last)   | Dward  12. Was Decedent Ever in U.: Armed Forces? 1   | S. 13. Was Decilif Yes, sp  1                     | ual Occupation ork done during most of w use retired)  General Help  18. Mother's No. as (Street and Number or F | Specify Yes or No- orking 16  ame (First, Middle, Ma Mary Bural Route Number, C tt City, Marylan, Date 20 2 7 - 0 5 | g. Citizen of What C  14. Race - Am Bfack, Wh Specify:  5b. Kind of Busines:  aiden Sumame) Unknown City or Town, State, d 21043 bc. Location - City of | 10d. Inside City Limits 1 Yes 2 No ountry? S.A. erican Indian, ite, etc. White Mindustry abor |
| 8760,                          | Physician /Medical Examiner and physician and physician and physician and the burial-transit  | dical Examiner                      | 23a. Part1. Exter the disease of compshock, or heart failure. List only of the compshock of | b. Due to (or as a consequence.  Due to (or as a consequence.  Due to (or as a consequence.  Due to (or as a consequence.  Due to (or as a consequence. | Do not enter the movement of):  VeSSe/ vence of): | 15 Chem  | a Pike, Fillicottes   |   | Approximate Interval Between Onset and Death  |
| P.O. Box 68                    | death certific<br>e attending p<br>ed for use as  | Physician/Med                       | in the past 12 menths?  1 Yes 2 No 9 Unknown   | 23c. If yes, outcome of pregnar<br>1 □ Live birth 2 □ Fetal ·<br>4 □ Pregnant at time of de<br>9 □ Unknown  | death 3 ☐ Ectopic p<br>eath 5 ☐ Other (s          | pecify)  |   | 23d. Date of de<br>Month  | livery<br>Day Year  |
| of Vital Records,              | : The law requires that the cete has been signed by th page 2 should be detache   | Completed by                        | Part II. Other significant conditions co   | ntributing to death but not resul   | Iting in the underlying                           | cause given in Part I.   | 1 Yes 24a. Was an autopsy performe  | 24b. Were a   | o the cause of death?  robably 4 Unknown  utopsy findings available completion of cause of    |
| Division of Vita               | il or Attending Physician: 1<br>after death.<br>Director: After this certificel<br>In by the funeral director, p  | ertification; To Be                 | 25. Was case referred to medical examiner?  1   Yes   O No    27. Manner of Death 1   Natural   5   Pending investigation 3   Suicide   6   Could not be determined  |   | me, farm, street, factor                          | OA Other: 4 Nursing<br>28c. Injury at<br>Work?<br>1 Yes 2 No   | ath Check only one) Home 5 Residence 28d. Describe how  28f. Location (Stree City or Town, 5                        | injury occurred   |   |
|                                | To the Hospital or Atten within 24 hours after deal within 24 hours after deal To the Funeral Director:   | Medical C                           | 29a. Certifier (Chick of) 29b. Signature and title of certifier  30. Name and address of person who co COLOD DLU BS 7  31. Date filed (Month, Day, Year)  DEC 2, 8, 201  | 32. Hegistrar's Signatu   | 29 23a) (Type, Print) 2AL More                    | at the time, date and place, in my opinion, death occ.  License number  D 3 15 7 5                               | urred at the time, date   | and place, and due  Date signed (Mont   | to the cause(s) h. Day, Year)   |

|                |  |                | 1 - State Amend Item 5 Per F   | of Maryland<br>H, C851, OI  | /Outo                                | rtment of H<br>fdhb<br>tilicate of L  | ealth and Me<br>Death                                    | ental Hygier                                     | 005  | 1871   |
|----------------|--|----------------|--|---|--------------------------------------|---|--|--|--|--|
|                | Physici<br>/Medic  |                | 1. Decedent's Name (First, Middle, Last) VIRGINI   | A F.  | SENTZ                                |   |  | 2. Date of Death<br>Month - 27                   | <sup>2</sup> 2005                                | 3. Time of Death 6:10 A. M                         |
|                | Examin   |                | 4a. Facility Name (If not institution, give street and not 2009 RUXTON ROAD                                  | umber)  |                                      | 4b. City, Town, or  | Location of Death  |  | 4c. County of Death                              | IMORE  |
|                | Funeral<br>Director  |                | 5. Social Security Number 6. Sex 1 M XX F  | 7. Age (In yrs. Ia.<br>87   | st birthday)<br>Yrs.                 | If Under 1 Year<br>Months Days  |  | B. Date of Birth<br>(Month, Day, Yea<br>02-21-19 |  | place (State or Foreign<br>http://                 |
|                | ow et  |                | Usual Residence of Decedent  10a. State 10b. County  | 10c. City,  | Town or Lo                           | cation  |  |  |  | Od. Inside City Limits                             |
|                | Ba-f sh  | Director       | MD. BALTIMORE  |   |                                      | TOWS  | SON  |  |  | 1 □ Yes 🏋 No                                       |
|                | th with th<br>23a or 21<br>ust be re   |                | 10e. Street and Number<br>2009 RUXTON ROAD   |   |                                      | 10f. Zip Code<br>2.   | 1204   | 10g. (   | U. S.  | •  |
| 980            | be filed within 72 hours after death with the Maryland ital Hyglene. id other than "natural", or Itams 23a or 28a-f show evant, I'm McJical Exir. if writinal Le ricilias and              | by Funeral     | Armed I  | 2 <b>XX</b> No  | 1                                    | Vas Decedent of His<br>Yes, specify Cubar                                   | spanic Origin? (Spec<br>n, Mexican, Puerto R<br>Specify: | ify Yes or No-<br>ican, etc.)                    | 14. Race - Americ<br>Black, White,<br>Specify: W |  |
| 21215-0036     | e filed within 72 h<br>at Hygiene.<br>other then "netu<br>vent, the Medical  | Completed      | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College 12 YEARS | (1-4or 5+)  | (Give                                | lent's Usual Occupa<br>kind of work done d<br>DO NOT use retired)<br>HOUSEW | uring most of working                                    | 16b.   | Kind of Business/In  OWN HOME                    |  |
| Maryland ?     | should be filed<br>nd Mental Hygi<br>markad othar<br>imatic evant, I   | To Be C        | 17. Father's Name (First, Middle, Last)  WARREN  | HAMPTON   |                                      |   | 18. Mother's Name (<br>ERNEST                            |  | en Sumame)<br>IROEDER                            |  |
|                | is 1 and 2 should<br>of Health and Mer<br>itam 27 is marka<br>other traumatic  |                | 19a. Informant's Name/Relationship ( <i>Type, Print</i> ) RICHARD T. KOEHLER (GRA                            | ANDSON)   |                                      |   | nd Number or Rural<br>D TRAIL, HA                        |  |  |  |
| Baltimore,     | Page<br>ent o<br>nt: If<br>ry or   |                | 20a. Method of Disposition  XXBurial 2 Cremation 3 Removal from  4 Donation 5 Other (Specify)                | n State cen   | netery, cren                         | sition (Name of<br>natory or other place<br>CEMETERY                        |  |  | Location - City or To                            |  |
| Balt           | permit. I<br>Departm<br>Importar<br>any inju   |                | 21. Signature of Funeral Service Licensee  | R.G.RUTH)   |                                      | UCK TOWSO   | s of Facility N FUNERAL                                  | HOME, INC  | 1050 YOU<br>• TOWSON,                            | RK ROAD<br>MD.21204                                |
|                | Pnysician<br>/Medical<br>Examiner  |                |  | caused the death. each line.  | 119/                                 | er the mode of dying  |  | respiratory arrest,                              |  | Approximate<br>Interval Between<br>Onset and Death |
| 8760, 年        | ficate be executed physician and sthe burial-transit   | dlcal Examiner | Cause (Disease or injury that initiated events c.  | o (or as a conseque   |                                      |   |  |  |  |  |
| O. Box 6       | The law requires that the death certifics the has been signed by the attending phage 2 should be detached for use as to  | Physician/Med  | in the past 12 months?   | utcome of pregnand<br>birth 2   Fetal d<br>gnant at time of dea<br>nown | eath 3                               | Ectopic pregnancy<br>Other (specify)  |  |  | 23d. Date of delive<br>Month                     | ory<br>Day Year                                    |
| rds, P         | w requires that<br>been signed b<br>should be deta   | by             | Part II. Other significant conditions contributing to  | death but not result  | ing in the ur                        | derlying cause give   | n in Part I.   |  | use contribute to the                            |  |
| Vital Records, | The law requate has been page 2 should   | Completed      |  |   |                                      |   |  | 24a. Was an autopsy performed?                   | prior to cor<br>death?                           | psy findings available inpletion of cause of       |
| Vita           | sician: Th<br>certificate<br>irector, pag  | Be             | 25. Was case referred to medical examiner?  1 Yes 2 No Hospital:   | 31  | 2/0-1                                | Othe  | 26. Place of Death                                       |  |  |  |
| on of          | ding Physician: n. After this certific funeral director,   | ion: To        | 27. Manner of Death  1 Natural 5 Pending (Mo   |   | R/Outpatien<br>8b. Time of<br>Injury | 28c. Injury<br>Work   | at 28  | e 5 Residence<br>d. Describe how inj             | 6 □Other (Specify ury occurred                   | /)   |
| Division       | To the Hospital or Attending Physician: To the Minip 24 hours after dealth as the certifics To the Funaral Director: After this certifics completely filled in by the funeral director, it | Certification: |  | e of Injury - At hom<br>ding, etc. (Specify)                            | e, farm, stre                        |   | es 2 No  | f. Location (Street a<br>City or Town, Sta       | and Number or Rura<br>te)                        | l Route Number,                                    |
| _              | A Hospita<br>24 hours<br>Funaral<br>etely filled   | Medical C      | 29a. Certifier (Check only one)  Certifying Physician: To the 2 Medical Examiner: On the and ma              | ne best of my knowledges basis of examination of the stated.            | edge, death<br>n and/or inv          | occurred at the time<br>estigation, in my opi                               | e, date and place, an<br>inion, death occurred           | d due to the cause(<br>at the time, date a       | s) and manner as st<br>nd place, and due to      | ated.<br>the cause(s)                              |
|                | To th<br>within<br>To the<br>compl   | Me             | 29b. Signature and title of certifier  | mo  |                                      | 29c. License  | 9/11   | 12   | ate signed (Month,                               | 5  |
|                | 6  |                | 30. Name and address of person who completed of  | use of death (Item 2  | (Type, I                             | Print)  | theru  | 1/2 11   | 7. 2116  | 3  |
|                | Sta<br>Registr   |                | 31. Date filed (Month, Day, Year) a32.   | Registrar's Signatur  | Const.                               | U   | , , , - , , ,  |  | <u></u>  |  |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Day Year Glen Thomas Swank 26, December 2005 2:30 A /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Oak Crest Care Center Baltimore Parkville Year | If Under 24 Hrs. If Under 1 Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Months 1 € M 2 □ F Director 198-01-7308 90 Yrs. December 20, 1915 Pennsylvania Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28e-f show in than "neturel", or Items 23e or 28e-f show the Wedical Examinar must be notified at 1 Yes 2 No Director Maryland Baltimore Parkville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8820 Walther Boulevard 21234 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 □XYes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No þ Specify. 3 Widowed 4 Divorced IIWhite Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Engineer Armco Steel n/a other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 2 should be find and Mental Find Mental Find Mental Find Mental Find Mental Find Mental Otto Find Mental Find Ment Robert Swank Mary Lauber 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 sh Department of Health and Importent; If item 27 Is rr any injury or other treum once. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Thomas Swank (Son) 574 Wildflower Trail Myrtle Beach, South Carolina 29579 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 

■ Burial 2 □ Cremation 3 □ Removal from State \* 4 ☐ Donation 5 ☐ Other (Specify) Dulaney Valley Mem. Gdns. 12/28/2005 Timonium Maryland 21. Signatu 22. Name and Address of Facility 21204 Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Md or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. 23a. Part 1. Enter the disease shock, or heart failure. I Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Priysician /Medical Due to (or as a consequence 11) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence ot): Examiner burial-transit attending physician and for use as the burial-tran Due to (or as a consequence ot): Physician/Medical 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Dav Year 4□Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No be detached signed by the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 No 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Hursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 🗌 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day Year) 27. Manner of Ceath 28b. Time of 28d. Describe how injury occurred Certification; atural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one)

TEN SEAN

the Maryland

Baltimore, Maryland 21215-0036

10+

State Registrar 31. Date filed (Month, Day, Year) DEC 2 8 2005

29b. Signature and title of certifier



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29d. Date signed (Month, Day, Year)

DHMH 17 Rev 1/2001

Registrar

DEC 2 8 2005

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For Stata Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month Year RANDALL SIEGMEISTER DECEMBER 25 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HOSPICE OF BALTIMORE-GILCHRIST BALTIMORE 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth (Month, Day, Year) 1 M 2 □ F Director 215-48-8484 49 02/05/1956 FLORIDA Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits nd 2 should be filed within 72 hours after death with the Maryla th and Mental Hygiene. 27 Ia marked other than "naturel", or items 23a or 28a-1 ahov traumatic event, the Medical Examinating the trialified at MD BALTIMORE Be Completed by Funeral Director TOWSON 1 ☐ Yes 2 No 10e. Street and Number 10f. Zio Code 10g. Citizen of What Country? 1229 WINE SPRING LANE 21204 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Yes 2 No
If Yes, Give
Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Pes 2 No Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) ENGINEER SOUND 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ္ ROBERT SIEGMEISTER EVELYN STIBER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: if item 27 Ia rr any injury or other traum once. MARGARET SIEGMEISTER / WIFE 1229 WINE SPRING LANE-TOWSON, MD 21204 20b. Place of Disposition (Name of cometery, crematory or other place)
ANSHE EMUNAH 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ② Donation 5 ☐ Other (Specify) 12/27/2005 BALTIMORE, MD CHAIM 22. Name and Address of Facility AITZ 21. Signature of Funeral Service Licensee SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death tmmediate Cause (Final disease or condition resulting in death) **Physician** months Pancireatic Cancel /Medical Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine Division of Vital Records, P.O. Box 68760 that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Medical Certification; To Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Dother (Specify) NSP ( 1 Yes 2 No 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 
Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours e To the Funeral I completely filled Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed (Month, Day, Year)
DEC 2 8 2005

AMON CHANUES

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32 Registrar's Signature

WV)

GLOI N. CHINES ST POWSON MO ZIZERA

D 58303

December 25 2005

|                   |  |                | For   | State of Marylan                                  |                                |   |                       | Mental Hyg              | giene                         | 1 1071   |
|-------------------|--|----------------|---|---|--------------------------------|---|-----------------------|-------------------------|-------------------------------|--|
|                   |  |                | 1 - State<br>Registrar  |   | Ce                             | rtificate of  | Death                 |                         | Reg. No. UUJ                  | 41875  |
|                   | Physici  | an             | Decedent's Name (First, Middle, Last  | +   |                                |   |                       | 2. Date of Dea<br>Month | Day Year                      | 3. Time of Death                                   |
|                   | /Media   | cal            | 4a. Facility Name (If not institution, give   | nomas   |                                | 4b. City, Town, o   | al continue of Dan    | Decemb                  |                               | 12:10 A <sup>M</sup>                               |
|                   | Examir   | ier            | Bon Secours Hosp  |   |                                | Balti   |                       | ım                      | 4c. County of Death           |  |
|                   | Funeral  |                | 5. Social Security Number 6. S  |   | last birthday)                 | If Under 1 Year   | If Under 24 Hr        |                         | h 9. Birth                    | place (State or Foreign                            |
|                   | Director   |                | 219-18-1924   | M 20% F 8/  | Yrs.                           | Months Days   | Hours Min             | (Month, Da)             | 1924 Pen                      | nsylvania  |
|                   | 2 2  |                | Usual Residence of Decedent  10a. State 10b. County   | 100 Cit   | y, Town or Lo                  | anting  |                       |                         |                               |  |
|                   | ehov   | 7              | Toa. State Tob. County  |   |                                |   |                       |                         |                               | 10d. Inside City Limits<br>1 Yes 2 ☐ No            |
|                   | 289-1  | Director       | 10e. Street and Number  |   | altin                          | 10f. Zip Code   |                       |                         | 10g. Citizen of What Cou      |  |
|                   | a or   | 큡              | 1700 Westers  | ad Aug  |                                | 7/1   | 17                    |                         | / / C                         | A.   |
|                   | deeth<br>ms 2;   | Funeral        | 11. Marital Status  | 12. Was Decedent Ever in U.                       | S. 13.                         | Was Decedent of H   | ispanic Origin? (     | Specify Yes or No-      | 14. Race - Ameri              | can Indian,  |
| 9                 | or Ite   | Ē              | 1 Never Married 2 Married   | Armed Forces?<br>1 ☐ Yes 2 7 No                   |                                |   |                       | rto Rican, etc.)        |                               | etc.   |
| 93                | ours<br>iral',   | d by           | 3 ☐ Widowed 4 ☐ Divorced  | If Yes, Give<br>Year or Dates:                    |                                | 1 ☐ Yes 2 ☑ No  | Specify:              |                         | Specify: Bla                  | CK   |
| 215-0036          | within 72 hours after deeth with the Maryland<br>ane.<br>then "natural", or items 23e or 28e-f ehow<br>ite Medical Examirer results he neitified at  | Completed      | 15. Decedent's Ed<br>(Specify only highest gra  |   | (Give                          | dent's Usual Occup<br>kind of work done o<br>DO NOT use retired | during most of wo     | orking                  | 16b. Kind of Business/Ir      | dustry   |
| 212               | within<br>lene.<br>then  | m<br>d<br>m    | Elementary/Secondary (0-12)   | College (1-4or 5+)                                |                                | Nurse   | ")                    |                         | Privicto                      | Diety  |
|                   | filed<br>Hygin<br>other  | a l            | 17. Father's Name (First, Middle, Last)   |   | /                              | varse   | 18. Mother's Na       | me (First, Middle,      | Maiden Sumame)                | Dury   |
| lan               | ould be<br>Mental<br>Marked o  | To B           | Toving Hic  | KS  |                                |   | Hanri                 | OTTO T                  | acobe                         |  |
| Maryland          | 2 shou<br>and M<br>is man  |                | 19a. Informant's Name/Relationship (  | Type, Print)                                      | 19b. Mailir                    | ng Address (Street  | and Number or R       | lural Route Numbe       | r, City or Town, State, Zij   | Code)  |
|                   | and 2<br>eelth<br>n 27 i   |                | Mr. Matthew T.  | homas   | 1709                           | Westwa  | ood Ave               | Baltu                   | more md.                      | 21217  |
| ore               | of He<br>of He<br>or oth   | l i            | 20a. Method of Disposition 1 ★ Burial 2 □ Cremation 3 □   | 1 -   | lace of Dispo<br>emetery, crer | sition (Name of matory or other place                           | 1                     | Date                    | 20c. Location - City or T     | own, State   |
| Baltimore         | permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Marylan Department of Heelth and Mental Hygiene. Importants if Item 27 is marked other then "natural", or Items 23s or 28s-1 show Importants if Item 27 is marked other then "natural", or Items 23s or 28s-1 show any Injury or other treamatic event, the Medical Exacilization and once. |                | 4 □Donation 5 □ Other (Specific   | ) A H   | buti                           | 15 Mem  | 12-                   | 31-2005                 | Baltimor                      | emd.   |
| Ball              | permit. Departr Importa  |                | 71. Signatule of Funeral Service Licer  | 900   | 3                              | Name and Addre  | ss of Famility        | Funera                  | 1 Home P. more Md.            | 4.   |
|                   | 40300  |                | 220 Botty Enter the decrees or com  | citizens that caused the death                    | O Do not ont                   | 7222 W.   | North A               | ve. Balti               | more, md.                     | 21216  |
|                   |  |                | 23a. Part#. Enter the disease, or com<br>shock, or heart failure. List only<br>Immediate Cause (Final                             |   |                                |   |                       |                         |                               | Approximate<br>Interval Between<br>Onset and Death |
|                   | Physician<br>/Medical  |                | disease or condition resulting in death)  | a. HypenTensive                                   | E ATM                          | FROSCIBRE   | ic cano               | 110 VYSCULA             | a DISSEASE                    |  |
| н                 | Examiner   |                |   | Due to (or as a consequ                           | uence or):                     |   |                       |                         |                               |  |
|                   |  | Je.            | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events | b. Due to (or as a conseq                         | uence of):                     |   |                       |                         |                               |  |
| ,                 | cuted  | Examiner       | Cause (Disease or injury that initiated events  | c   |                                |   |                       |                         |                               |  |
| ő,                | e exe  | Ä              | resulting in death) Last  | Due to (or as a consequ                           | uence of):                     |   |                       |                         |                               |  |
| 8760,             | icate be executed<br>physicien and<br>the burial-transit   | dicai          |   | d   |                                |   |                       |                         |                               |  |
| 9                 | leath certific<br>attending p  | /Me            | IF FEMALE:  | 23c. If yes, outcome of pregna                    | nev                            | · · · · · · · · · · · · · · · · · · ·                           |                       |                         |                               |  |
| Вох               | atten<br>for u   | clan           | 23b. Was decedent pregnant in the past 12 months?   | 1 Live birth 2 Fetal                              | Ideath 3                       | Ectopic pregnancy Other (specify)                               |                       |                         | 23d. Date of deliver Month    | ery<br>Day Year                                    |
| P.0.              | The law requires that the death certifi<br>He has been signed by the attending<br>age 2 should be detached for use as  | Physician/Me   | 1 ☐ Yes 2 No<br>9 ☐ Unknown   | 9□ Unknown  |                                |   |                       |                         |                               |  |
|                   | res that<br>igned b  | by Pi          | Part If. Other significant conditions of  |   | -                              | nderlying cause giv   | en in Part I.         | 23e. Did to             | bacco use contribute to t     | he cause of death?                                 |
| of Vital Records, | w require<br>been sig<br>should b  | edr            | DIABETES N<br>SEIZURE DISC  | vecilTus,   | KAT                            | TYLIV   | EZ_                   | 1 🗆 Y                   | es 2. No 3 □ Prot             | oably 4 Unknown                                    |
| 000               | e law re<br>has be<br>je 2 sho   | Completed      | SFIZURE DISC  | ROBR  |                                |   |                       | 24a. Was a autops       | an 24b. Were auto             | ppsy findings available mpletion of cause of       |
| <u> </u>          |  | E C            |   |   |                                |   |                       | perfor                  | med? death?<br>2 ☐ No 1 2 Yes |  |
| /ita              | sician: Th<br>certificate<br>rector, pag   | Be             | 25. Was case referred to medical examiner?  |   |                                |   |                       | ath (Check only or      | 16)                           |  |
| of                | S 0 70   | ၉              | XXYes 2 No  |   | ER/Outpatien                   |   | 4 🗀 Nursing i         |                         | ence 6 Other (Special         | y)   |
| u                 |  | E I            | 27. Manner of Death  1 Natural 5 ☐ Pending investigation  | 28a. Date of fnjury<br>(Month, Day Year)          | 28b. Time of<br>Injury         | Worl  | γατ<br>⟨?<br>Yes 2∐No | 28d. Describe no        | ow injury occurred            |  |
| Division          | ten<br>feat<br>tor:<br>the   | fica           | 3 Suicide 6 Could not be  |   | ome, farm, str                 |   | 103 2 110             | 28f. Location (S        | treet and Number or Rura      | Al Route Number                                    |
| Ş                 | after<br>Dire  | Certification: | 4 Homicide determined   | building, etc. (Specify                           | 1)                             | ,, ,, ,   |                       | City or Town            |                               |  |
|                   | bours<br>hours<br>unere  |                | 29a. Certifier 1 Certifying Ph  | ysician: To the best of my kno                    | wiedge, death                  | occurred at the tin   | ne, date and plac     | e, and due to the c     | ause(s) and manner as s       | tated.   |
|                   | To the Hospitel or Attending within 24 hours after death.  To the Funerel Director: After completely filled in by the fune.  | Medical        | one)  | niner: On the basis of examina and manner stated. | uon and/or in                  | vestigation, in my o  | oinion, death occ     | urred at the time, d    | late and place, and due to    | the cause(s)                                       |
|                   | To t<br>To t   | Σ              | 29b. Signature and title of certifier   |   |                                | 29c. License  | e number              | 2                       | 29d. Date signed (Month,      | Day, Year)   |
|                   | Λ  |                | 1   | 1   |                                | OCM   | <u> </u>              | I                       | December 23,                  | 2005   |
|                   | 3  |                | 30. Name and address of person who  | completed cause of death (Item                    | 23a) (Type,                    |   | Stroot                | Raltimo                 | ore, Marylan                  | d 21201  |
|                   | Sta  | to.            | 31. Date filed Month, Day, Yound no   | 32. Registrar's Siera                             | ture Ange                      | III reil  | ı prieer              | Dartill                 | re, raryran                   | U 212U1  |
|                   | Registr  |                | DEO 6 0 200   | AND SHALL AS                                      | 1                              |   |                       |                         |                               |  |

| -             | Adam T  | VS.         |  | State of Maryland / Depa  |   |   | •                              |  |  |  |  |
|---------------|---|-------------|--|---|---|---|--------------------------------|--|--|--|--|
|               |   | ., .        | 1 - For State Registrar  |   | rtificate of Death  |   | 2005                           | 41876  |  |  |  |
|               |   |             | Decedent's Name (First, Middle, Last   |   | unoute of Death   | 2. Date of Death                        |                                | 3. Time of Death                                   |  |  |  |
|               | Physic  |             | NIGEL A. TYS   | ON  |   | Month                                   | Day Year 23. 2005              | 9:35 P <sup>M</sup>                                |  |  |  |
|               | /Medi<br>Examir   |             | 4a. Facility Name (If not institution, give  | street and number)  | 4b. City, Town, or Location of Dea  |   | 4c. County of Deat             |  |  |  |  |
|               |   |             | 2601 Madison Aven  | ue Apt. 1106  | Baltimore City  |   | N/A                            |  |  |  |  |
|               | Funeral   |             | 5. Social Security Number 6. Se 580-25-6944  | 7. Age (In yrs. last birthday)  19 Yrs.                               | If Under 1 Year If Under 24 Hr<br>Months Days Hours Mir                   | (Month Day                              | Year) 9. Birt.                 | hplace (State or Foreign<br>untry)                 |  |  |  |
|               | Director  |             | Usual Residence of Decedent  | 17 113.   |   | 06/21/                                  | 1986 VIF                       | RGIN USLAN   |  |  |  |
|               | yland   |             | 10a. State 10b. County   | 10c. City, Town or Lo   | ocation   |   |                                | 10d. Inside City Limits                            |  |  |  |
|               | e Mar   | ctor        | MD N/a   | BALTIM  | ORE CITY  |   |                                | 1 <b>X</b> Yes 2 □ No                              |  |  |  |
|               | with the Maryland<br>a or 28a-f ahow<br>Lenvilled at  | Director    | 10e. Street and Number   | AUT ADM #1106   | 10f. Zip Code   | 10                                      | g. Citizen of What Co          | untry?   |  |  |  |
|               | death with the Maryland<br>ms 23a or 28a-f ahow<br>Titual be notified at  | ral         |  | AVE., APT. #1106  | 21217   |   | USA                            |  |  |  |  |
| _             | à ≗ ª   | Funeral     | 11. Marital Status  1 ☒ Never Married 2 ☐ Married  | 12. Was Decedent Ever in U.S. Armed Forces?                           | Was Decedent of Hispanic Origin? (<br>If Yes, specify Cuban, Mexican, Pue | Specify Yes or No-<br>into Rican, etc.) | 14. Race - Ame<br>Black, White |  |  |  |  |
| 2             | hours after<br>ural', or its  | þ           | 3 ☐ Widowed 4 ☐ Divorced   | 1 ☐ Yes 2 X No If Yes, Give Year or Dates:                            | 1 ☐ Yes 2 ☐XNo Specify:   |   | Specify: BI                    | ACK  |  |  |  |
| ה<br>ה        | 22 8 3  | Completed   | 15. Decedent's Edu<br>(Specify only highest grad   | ucation 16a. Dece   | dent's Usual Occupation<br>kind of work done during most of w             | orking 10                               | 5b. Kind of Business/          | Industry   |  |  |  |
| 7             | within ene.   | lg.         | Elementary/Secondary (0-12)  | College (1-4or 5+)  | DO NOT use retired)   | orking .                                | PAINT                          | IMOD GO  |  |  |  |
| Z             | iled w<br>Hygier<br>Iher ti   |             | 12TH 17. Father's Name (First, Middle, Last)   | 1 YEAR LA   | BORER   | one (Fine Mindel - M                    | DISTRIBU                       | TOR CO.  |  |  |  |
| ala           | d be f  | Be C        | NIGEL A. TYS   | OM  |   | ame (First, Middle, Ma                  | ,                              |  |  |  |  |
| <u></u>       | Shoul<br>nd Me<br>mark  | 2           | 19a. Informant's Name/Relationship (T)   |   | ng Address (Street and Number or F  | IILDA ART                               |                                | in Code)   |  |  |  |
| Ž             | s 1 and 2 shoul<br>f Health and M<br>item 27 is marl<br>other traumati  |             | NIGEL A. TYSON   |   | 4 CALLAWAY AVE  |   |                                |  |  |  |  |
| e G           | es 1 a<br>of Hea<br>of Hea<br>litem   |             | 20a. Method of Disposition   | 20b. Place of Dispo   |   |   | c. Location - City or          |  |  |  |  |
| Ĕ             | . Pages<br>Iment of<br>tent: If it<br>iury or o   |             | 1 Burial 2 ☐ Cremation 3 ☐ F<br>4 ☐ Donation 5 ☐ Other (Specify)                                       | TOTALON TOTALON   |   | 30/05 B                                 | ALTIMORE                       | , MD   |  |  |  |
|               | permit. Pa<br>Departmer<br>Importent<br>any Injury<br>once.   |             | 21. Signature if Pineral Service Licens  | ee 222  | . Name and Address of Facility  | OWELL FU                                | NERAL HO                       | ME 21207   |  |  |  |
|               |   |             | 11 Julyne  | 10. Vous  | A600 LIBERTY E  | ETCHEC A                                | 77E DAT                        | TIMORE, M  |  |  |  |
|               |   |             |  | ications that caused the death. Do not ent<br>ne cause on each line.  | er the mode of dying, such as cardia                                      | ac or respiratory arres                 | t,                             | Approximate<br>Interval Between<br>Onset and Death |  |  |  |
|               | Physician<br>/Medical   |             | Immediate Cause (Final disease or condition resulting in death)  | a Multiple she  | arp force in  | furies                                  |                                |  |  |  |  |
|               | Examiner  |             |  | Due to (or as a consequence of):                                      | V   |   |                                |  |  |  |  |
|               |   | Je.         | Securitiesly flat conditions if any, leading to immediate  | Due to (or as a consequence of):                                      |   |   |                                |  |  |  |  |
|               | ate be executed<br>nysicien and<br>he burial-transit  | Examiner    | if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c. |   |   |   |                                |  |  |  |  |
| ,00           | e exe   |             | resulting in death) Last   | Due to (or as a consequence of):                                      |   |   |                                |  |  |  |  |
| -             | cate b  | dlcai       |  | d   |   |   |                                |  |  |  |  |
| 9<br><b>X</b> | The law requires that the death certifical ate has been signed by the attending phy page 2 should be detached for use as the  | ician/Med   | IF FEMALE:   | 23c. If yes, outcome of pregnancy                                     |   |   |                                |  |  |  |  |
| 2             | atten<br>for u  | cian        | in the past 12 months?   | 1 Live birth 2 Fetal death 3 □  | Ectopic pregnancy Other (specify)   |   | 23d. Date of deli              | very<br>Day Year                                   |  |  |  |
| į             | the d<br>by the<br>ached  | Physi       | 1 ☐ Yes 2 ☐ No<br>9 ☐ Unknown  | 9☐ Unknown  | , or (speed))   |   |                                |  |  |  |  |
| Ļ             | is that<br>gned t   | by P        | Part II. Other significant conditions con  | ntributing to death but not resulting in the ur                       | nderlying cause given in Part I.  | 23e. Did toba                           | cco use contribute to          | the cause of death?                                |  |  |  |
| č<br>S<br>S   | aquire<br>en sig<br>buid b  |             |  |   |   | 1 🗆 Yes                                 | No 3□Pro                       | obably 4 Unknown                                   |  |  |  |
| ร             | law ras be  | Completed   |  |   |   | 24a. Was an autopsy                     |                                | topsy findings available ompletion of cause of     |  |  |  |
| <u>ح</u>      | The<br>cate h<br>page   | Con         |  |   |   | performe                                | id?   death?                   | 2 No   |  |  |  |
| 2             | iclan:<br>Sertific<br>ector,  | Be          | 25. Was case referred to medical examiner?   | Jana itali  |   | ath (Check only one)                    |                                |  |  |  |  |
| 5             | Physical dir  | 5           | 1 XXes 2 No 27. Manner of Death  | lospital: 1 Inpatient 2 ER/Outpatien 28a. Date of Injury 28b. Time of |   | Home 5 Residen                          | 2121                           | (fy) Scene   |  |  |  |
| 5             | ding<br>After<br>funer  | tion:       | 1 □Natural 5 □ Pending   | (Month, Day Year) Injury  | 28c. Injury at Work? 1 ☐ Yes 2 🗷 No                                       | 28d. Describe how                       | ,                              | CA   |  |  |  |
| 2             | Atten r deat ctor:  | fica        | 3 ☐ Suicide 6 ☐ Could not be   | 28e. Place of Injury - At home, farm, stre                            | · VU  | 28f. Location (Stre                     | table and Number or Ru         | ral Route Number.                                  |  |  |  |
| 5             | s after   | Certificati | 4 Homicide determined  | building, etc. (Specify)  | home  | City or Town, State) 2 to i A           |                                |  |  |  |  |
|               | hour<br>hour<br>uners   |             | 29a. Certifier 1 Certifying Physical Check only 2 Madical Exemi  | sician: To the best of my knowledge, death                            | occurred at the time, date and place                                      | e, and due to the cau                   | se(s) and manner as            | stated.  |  |  |  |
|               | To the Hespitel or Attending Physician: The law requires that the death certifical within 24 hours after death. within 24 hours after death. completely filled in by the funeral director, page 2 should be detached for use as the | Aedicai     | one)   | ner: On the basis of examination and/or inv<br>and manner stated.     |   |   |                                |  |  |  |  |
|               | S S S   | Σ           | 29b. Signature and title of certifier  | Ap C  | 29c. License number   | d. Date signed (Month, Day, Year)       |                                |  |  |  |  |
|               | 1.  |             | Cabilla  |   | OCME  | D                                       | ecember 24                     | +, 2005  |  |  |  |
|               | W   |             | 30. Name and address of person who co  | ompleted cause of death (Item 23a) (Type, Baltimore, M                | arvland 21201 7   | MBILLAI                                 | +AC                            |  |  |  |  |
|               |   | 1           |  | ,   |   | . / * * * * * * * * * * * * * * * * * * | 1                              |  |  |  |  |

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

ORIGINAL

32. Registrar's Signature

|     |                                |  |                | State of Maryland / Department of Health and No. 1 - State Registrar Amend Item #31 PEr DVR C850 Centificates of Meanth  |  | 2000                                       | 41877  |
|-----|--------------------------------|--|----------------|--|--|--|--|
|     |                                |  |                | 1. Decedent's Name (First, Middle, Last)   | 2. Date of Dea                             |  | 3. Time of Death                                       |
| _   |                                | Physici<br>/Medio  |                | Robert Joseph Tudor, Jr.   | Dec.                                       | 15 2005                                    |  |
|     |                                | Examir   |                | 4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death   |  | 4c. County of D                            |  |
|     | 1                              |  |                | Harford Memorial Hospital Havre de Grace   |  | Harfo                                      | rd   |
|     |                                | Funeral  |                | 5. Social Security Number 6. Sex 1 X Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Nonth Days Hours Min.  | 8. Date of Birth<br>(Month, Day<br>12/26/1 | 9. I                                       | Birthplace (State or Foreign<br>Country)<br>aryland    |
|     |                                | Director   | ļ              | 220-12-7989 78 Yrs.  Usuel Residence of Decedent   | 12/26/1                                    | 926 M                                      | arylana  |
|     |                                | laryland<br>show   |                | 10a. State 10b. County 10c. City, Town or Location   |  |  | 10d. Inside City Limits                                |
|     |                                | Man<br>a-f sh  | tor            | MD Harford Havre de Grace  |  |  | 1 X Yes 2 □ No   |
|     |                                | death with the Maryland<br>ms 23a or 28a-f show  | Director       | 10e. Street and Number 10f. Zip Code   | 1  | log. Citizen of What                       | Country?   |
|     |                                | 23a (23a ust b   |                | 617 Market Street 21078  |  | USA  |  |
|     |                                | or des<br>tams   | Funeral        | 11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  13. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto  | pecify Yes or No-<br>o Rican, etc.)        | 14. Race - A<br>Black, W                   | merican Indian,<br>hite, etc.                          |
|     | 36                             | ours after death with the Maryla<br>al', or Itams 23a or 28a-f shov<br>Examilier must be mallined at   | by F           | 1 ☐ Never Married 2 ☐ Married 1 ☒ Yes 2 ☐ No If Yes, Give Year or Dates: 1943-45   |  | Specify:                                   | White  |
|     | Ş                              | "natura  |                | 15. Decedent's Education 16a. Decedent's Usual Occupation  |  | 16b. Kind of Busine                        |  |
|     | 215                            | hin 7.   | Completed      | (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)  (Give kind of work done during most of work life. DO NOT use retired)   | king                                       |  |  |
|     | 21                             | ed wit   | Con            | 2 years Mechanic   |  | Vending M                                  | achines  |
|     | pu                             | be filed within that Hygiene. od other than event, the M   | Be             |  |  | Maiden Sumame)                             |  |
|     | yla                            | 2 should be filed within 72 hours after death with the M and Mental Hygiene. Is marked othar than "natural", or Itams 23a or 28a-f aumatic event, the Model Examination at the notifier. | 2              | Robert Joseph Tudor, Sr.  19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Ru  |  | City Town                                  | 7-0-41   |
|     | Mai                            | d 2 sl<br>th and<br>7 Is r<br>traur  |                |  |  | 21914                                      | e, Zip Code)   |
| 0   | ō,                             | Heal<br>Heal<br>tam 2  |                | 20a. Method of Disposition  20a. Method of Disposition  20b. Place of Disposition (Name of cometery, crematory or other place)   |  | 20c. Location - City                       | or Town, State   |
| 3   | OT.                            | ages<br>ent of<br>nt: If i   |                | 1 X Burial 2 □ Cremation 3 □ Removal from State  '4 □ Donation 5 □ Other (Specify)  Angel Hill Cemetery   12/2   | 0/05 H                                     | avre de G                                  | race MD  |
| Ob  | Baltimore, Maryland 21215-0036 | mit. F<br>oortar<br>oortar<br>injur  |                | 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Fun Milchell-Smith Fun  | - Inco                                     |  | recect, in   |
| \   | ä                              | permit. Pages 1 and 2 should be Deparmit. Pages 1 and Menta Inportant: If item 27 Is marked any injury or other traumatic evonce.  |                | Juaire 7. Some 123 S. Washington,  | Havre de                                   | Grace. M                                   | D 21078  |
|     |                                |  |                | 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line.  |  |  | Approximate<br>Interval Between                        |
|     | М                              | Physician  |                | Immediate Cause (Final disease or condition SCPTiC SCNCK   |  |  | Onset and Death  |
| _   | П                              | /Medical   |                | resulting in death)  Due to (or asia consequence of):  |  |  | 1 824  |
| h   |                                | Examiner   | _              | Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):   |  |  | 2 days   |
| 10  |                                | bed<br>isit  | Examiner       | if any, leading to immediate cause. Eine Underlying Cause (Disease or injury   |  |  | 0 11   |
| 2   |                                | xecul<br>and<br>al-tran  | xan            | that initiated events c.  Due to (or as a consequence of)  |  |  | 1 MONT NI  |
| //  | 8760                           | that the death certificate be executed<br>ed by the attending physician and<br>detached for use as the buriat transit  | dicalE         | stasis Wes   |  |  | 6 months   |
| 20  | 9                              | ifficate<br>g phy<br>as the  | ledle          | V.   |  |  |  |
|     | Вох                            | th cert<br>endin   | Physiclan/Me   | IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy   |  | 23d. Date of                               |  |
|     |                                | e deat<br>he att   | sicle          | in the past 12 months? 1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 5 ☐ Other (specify)  |  | Month                                      | Day Year   |
| 1   | P.0                            | at the   | Phy            | 9 C Ouknown  | 00a Did tai                                | bassa usa sastributa                       | a do dha anns af dardh?                                |
| 1   |                                | wrequires that the death<br>been signed by the atter<br>should be detached for u   | þ              | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   | 1 12/10                                    |  | to the cause of death?  Probably 4 □Unknown            |
| 2   | Vital Records,                 |  | Completed      | - Piaku  |  | -  |  |
| 9   | Rec                            | The law  | mp             |  | 24a. Was a autops perform                  | v prior 1                                  | autopsy findings available to completion of cause of ? |
| So. | a                              | n: Th  | e Co           | 25. Was case referred to medical 26 Place of Dea   | 1 ☐ Yes                                    | 2 2 No 1 □ Y                               | es 22No  |
| (X  |                                | ysician: The l<br>is certificate ha<br>director, page  | o B            | examiner?  | th (Check only on                          | ence 6 Other (S                            | necify)  |
| _   | of                             | g Phy<br>er this<br>neral c  | ı.             | 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at 1841.0   |  | ow injury occurred                         | pouny  |
| 2   | )<br>joi                       | auth.<br>r: Aft  | atlo           | 2 Accident investigation M 1 Yes 2 No  |  |  |  |
| Dok | Division                       | r Atterderinacte   | Certification: | 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   | 28f. Location (St<br>City or Town          |  | Rural Route Number,                                    |
| (2) | Ω                              | urs af<br>urs af<br>ural D   |                |  |  |  |  |
| 13  |                                | To the Hospital or Attending Physician: The law within 24 hours after death.  To tha Funaral Diractor: After this certificate has completely filled in by the funeral director, page 2.5 | edical         | 29a. Certifier  (Check only one)  1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and place of examination and/or investigation, in my opinion, death occur and manner stated. | , and due to the ca<br>rred at the time, d | ause(s) and manner<br>ate and place, and d | as stated.<br>fue to the cause(s)                      |
| 1   |                                | o the  | Me             | 29b. Signature and title of centrier 29c. License number   | 2  | 9d. Date signed (Mo                        | onth, Day, Year)                                       |
|     |                                | r ≤ r ō  |                | D06290   | 3  | 12/16/65                                   |  |
| ,   |                                | 161/   |                | 3A Name and address a person who completed cause of death (Item 23a) (Type, Print)   |  | 110  | 2:   |
| #3, | 2                              | 12,4   |                | ANAS ARAGIL 319 Surion Ave Harre D   | e Grace                                    | MD.  | 210+8  |
| 1   |                                | Sta  |                | 31. Date filed (Month, Day, Year)  32. Registar's Signature  DEC 2 8 2005  |  |  |  |
|     |                                | Regist   | al             | I - I I - PEON O CON PROMONED VO.  |  |  |  |

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** Ardell Tephabock 24, 6:50 PM DECEMBER 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Saint Joseph Medical Center Baltimore Towson | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Dec. 7, 19. 6. Sex ★ M 2 F 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 83 Director 218-16-1193 W.V. Usual Residence of Decedent death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or itams 23a or 28a-1 shov any Injury or other traumatic event, it a Marylar Example of the molified at Md. Baltimore Overlea 1 ☐ Yes 2 X No Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5623 North Lane 21206 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White Completed by 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) U.S. Postal Service Letter Carrier 8 yrs. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William L. Tephabock Susan R. Westfall ٥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Eileen Tephabock wife 5623 North Lane Baltimore Md. 21206 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Rossville Md. Gardens of Faith Cem. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Connelly Funeral Home Of Dundalk 7110 Sollers Foint Rd. 21222 once him 23a. P. ft1. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician a ACUTE MYOCARDIAL INFARCTION disease or condition resulting in death) 3 DAYS /Medical Due to (or as a consequence of): Examiner CORONARY ARTERY DISEASE YEARS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. the attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? jo Day Month Year 4☐Pregnant at time of death 5 Other (specify) signed by the a 9☐ Unknown 9 DUnknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ ector, page 2 should be RECENT RIGHT TOTAL KNEE REPLACEMENT Completed 3 Probably 1 ☐ Yes 2 ☐ No been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☑ Yes 2 ☐ No PSEUDOMEMBRANOUS COLITIS 24a. Was an has autopsy performed? certificate Yes 2 No CELLULITIS or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: Certification; To 1 Inpatient 2 ER/Outpatient 3 DOA funeral dir this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After 5 Pending investigation M 1 ☐ Yes 2 ☐ No death. the f 2 Accident Director 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. City or Town, State) filled in by To the Hospital or Al within 24 hours after or To the Funeral Direc 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature a the of certific 29c. License number 29d. Date signed (Month, Day, Year) attiologist D34543 1-25-05 30. Name and addless of person who completed cause of death (Item 23a) (Typel Print) STEVEN R. AXE. M 31. Date filed (Month, Day, Year) DEC 2 8 2005 7601 OSLER DRIVE, TOWSON, MARYLAND 21204 32 Registrar's Signature State Registrar

ROBERT

WILLIAM

|                |  |                  | 1 - For<br>State<br>Registrar   |  | aryland / De                      |  | t of H             | lealth a         | and M      | •                                 |                  | e<br>005              | e.             | 1879                                 |
|----------------|--|------------------|---|--|-----------------------------------|--|--------------------|------------------|------------|-----------------------------------|------------------|-----------------------|----------------|--------------------------------------|
|                | • Physici  | ian              | Decedent's Name (First, Middle, Last  |  | DODEDE                            | med by   |                    |                  |            | 2. Date of D<br>Month             | eath<br>Da       | y Ye                  | ear            | 3. Time of Death                     |
|                | /Medi  | cal              |   | WILLIAM                                    | ROBERT                            |  |                    |                  |            | DEC.                              | 23,              | 2005                  |                | 7:00 P                               |
| 1              | Examir   | ner              | 4a. Facility Name (If not institution, give   |  |                                   | 4b. City,                                      |                    | r Location (     |            | _                                 |                  | . County of [         |                |                                      |
|                | Funeral  |                  | CARROLL HOSPIT  5. Social Security Number 6. Se   |  | ER<br>e (In yrs. last birthda     | y) If Under                                    | 1 Year             | TMIN<br>If Under | 24 Hrs.    |                                   |                  | CARRC<br>9.           |                | ce (State or Foreign                 |
|                | Director   |                  | 216-12-6128   | ¶M 2□F                                     | 85 Yrs.                           | Months   | Days               | Hours            | Min.       | 8. Date of B<br>(Month, E<br>12/3 | $\frac{1}{19}$   | 0 M                   | Country        | ce (State or Foreigr<br>y)<br>LAND   |
|                | pu .   |                  | Usual Residence of Decedent  10a. State 10b. County   |  | 10c. City, Town or                | Landina  |                    |                  |            |                                   |                  |                       |                |                                      |
| _              | Maryland<br>-f show<br>lied al   | 5                |   |  |                                   |  | _                  |                  |            |                                   |                  |                       | 100            | d. Inside City Limits 1 □XYes 2 □ No |
|                | the N<br>28e-  | Funeral Director | MD. CARROLI  10e. Street and Number   | J  | WESTM                             | 10f. Zip                                       |                    |                  |            |                                   | 100 Ci           | tizen of Wha          | t Countr       |                                      |
|                | 3s or  | Ö                | 231 ST. MARK V  | JΛV  |                                   |  | 158                |                  |            |                                   | US               |                       | t Country      | y r                                  |
|                | death  | nera             |   | 12. Was Decedent E                         | Ever in U.S. 1                    |  |                    | ispanic Ori      | gin? (Spe  | ecify Yes or N<br>Rican, etc.)    |                  | 14. Race - A          |                |                                      |
| 9              | 72 hours after death with the<br>naturel', or Items 23s or 28e<br>ical Examiner must be noti   |                  | 1 ☐ Never Married 2X Married  | Armed Forces?<br>M☐Yes 2☐N<br>If Yes, Give | lo                                | If Yes, special of Yes                         |                    |                  |            | Rican, etc.)                      |                  | Black, V              | Vhite, et      | C.                                   |
| 5-0036         | urel',   | d by             | 3 Widowed 4 Divorced  | Year or Dates:                             | WWII                              | 10 165   | 283 140            | эрөспу.          |            |                                   |                  | Specify: T            | VHIT           | CE                                   |
| 15-            | n 72<br>"nat   | Completed        | 15. Decedent's Edu<br>(Specify only highest grad  | cation<br>e <i>completed)</i>              | (G)                               | cedent's Usua<br>ve kind of wo<br>i. DO NOT us | rk done o          | during mos       | t of worki | ng                                | 16b. K           | and of Busine         | ess/Indu       | stry                                 |
| 2121           | iene.<br>r then "  | E                | Elementary/Secondary (0-12)   | College (1-4or 5-                          | +)                                |  | rist               | ,                |            |                                   | NEW              | SPAPI                 | TR.            |                                      |
|                | e filed<br>Il Hyg<br>other   | Be C             | 17. Father's Name (First, Middle, Last)   |  |                                   |  |                    | 18. Mothe        | er's Name  | (First, Middl                     | 1                |                       |                |                                      |
| /lar           | should be<br>nd Mental<br>marked c   | To E             | CHARLES   | ARTHUR                                     | TERRY                             |  | İ                  |                  | ERM        | A E.                              | STE              | INACI                 | HER            |                                      |
| Maryland       | 2 sho<br>and !<br>is ma<br>euma  |                  | 19a. Informant's Name/Relationship (Ty  | pe, Print)                                 | 19b. Ma                           | iling Address                                  | (Street a          | and Numbe        | er or Rura | l Route Num                       | ber, City o      | or Town, Star         | te, Zip C      | ode)                                 |
| _              | and<br>ealth<br>m 27   |                  | ELLEN E. TERRY  | <u> </u>                                   | FE 231                            | ST. N  | IARK               | WAY              |            | ESTMI                             |                  |                       |                |                                      |
| Baltimore,     | ges 1<br>it of H<br>if ite<br>or ot  |                  | 20a. Method of Disposition  ∫1 □ Burial 2 ☑ Cremation 3 □ F   |  | 1                                 | rematory or o                                  | ther plac          | ·                |            | ate                               |                  | ocation - City        |                |                                      |
| ţ              | t. Pa<br>rtmen<br>rtent:<br>njury  | R 04             | 4 □ Donation 5 □ Other (Specify) 21. signatur of Fuller IS, rvice Liberts                                   | A  | Tr conn                           |  |                    |                  |            |                                   |                  |                       |                |                                      |
| Bal            | permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: if item 27 is marked other then "naturel", or Items 23s or 28e-f show any injury or other treumatic event, Ite Maxical Examiner must be notified at ance. |                  | 21. Signature of June 15, rvice Liberts   | 0  |                                   |  |                    |                  |            | TCHER                             |                  |                       |                |                                      |
|                | ē .  |                  | 23a, Part1, Enter / e diseas y or compl   | ications that caused                       |                                   |  |                    |                  |            |                                   |                  | STER,                 |                | . 21157                              |
|                | P  |                  | 23a. Part1. Enter * e diseas *, or compl<br>shock, or heart failure. List only or<br>Immediate Cause (Final | ne cause on each lin                       | θ.                                | anton tho mod                                  | o or ayırı         | 9, 30011 03      | cardiaco   | respiratory                       | arrest,          |                       | Ir             | nterval Between<br>Onset and Death   |
|                | Prrysician<br>/Medical   |                  | disease or condition resulting in death)  | Due to (or as a                            | a consequence of):                |  |                    |                  |            |                                   |                  |                       | 1              | DAYS                                 |
| 0              | Examiner   |                  |   | 0  | EUMON                             | 1 21   |                    |                  |            |                                   |                  |                       |                | DAVE                                 |
|                |  | je               | Sequentially list conditions, if any, leading to infinediate  |  | nonsequence of):                  | 77   |                    |                  |            |                                   |                  |                       |                | DAYS<br>YEARS                        |
|                | ate be executed hysician and the burial-transit  | Examiner         | cause. Enter Underlying Cause (Disease or injury that initiated events                                      | ALZ  | HEIMER                            | 'S D   | ISE                | ASE              |            |                                   |                  |                       | 1              | YEARS                                |
| 90,            | e exe<br>sian a<br>urial-  | E                | resulting in death) Last  | Due to (or as a                            | a consequence of);                |  |                    |                  |            | -                                 |                  |                       |                |                                      |
| 8760,          | cate b   | dlcal            |   | 1  |                                   |  |                    |                  |            |                                   |                  |                       | -              |                                      |
| 9 X            | or Attending Physicien: The law requires that the death certificate be executed tifter death.  Director: After this certificate has been signed by the attending physician and in by the funeral director, page 2 should be detached for use as the burial-transit.                              | Physician/Med    | IF FEMALE:  | 3c. If yes, outcome of                     | of pregnancy                      |  |                    |                  |            |                                   |                  |                       |                |                                      |
| Вох            | atter<br>atter   | cian             | in the past 12 months?  | 1 Live birth 2<br>4 Pregnant at t          | 2 Fetal death                     | Ectopic pr                                     |                    |                  |            |                                   |                  | 23d. Date of<br>Month | delivery<br>Da | ay Year                              |
| P.O.           | that the de<br>detached  | hysi             | 1 ☐ Yes 2 ☐ No<br>9 ☐ Unknown   | 9□ Unknown                                 |                                   |  |                    |                  |            |                                   |                  |                       |                |                                      |
|                | res that<br>signed to<br>be det  | by P             | Part II. Other significant conditions cor   | tributing to death bu                      | it not resulting in the           | underlying ca                                  | ause give          | en in Part I.    |            | 23e. Did                          | tobacco u        | ise contribut         | e to the       | cause of death?                      |
| rds            | w require<br>been sig<br>should b  | ed t             | MYECARDIAL  | INFAR                                      | CTION                             |  |                    |                  |            | 1 🗆                               | Yes 2            | □ No 3 □              | Probab         | ly 4 Hinknown                        |
| Vital Records, | ne law re<br>has be-<br>ge 2 sho   | Completed        |   |  |                                   |  |                    |                  |            | 24a. Was                          |                  | 24b. Were             | autopsy        | y findings available                 |
| Ä              | ysicien: The is certificate hadirector, page   | E O              |   |  |                                   |  |                    |                  |            |                                   | ormed?<br>2 ☐ No | death                 |                | letion of cause of<br>□ No           |
| /ita           | iicien: Th<br>certificate<br>rector, pag   | Be (             | 25. Was case referred to medical examiner?  |  |                                   |  |                    |                  |            | Check onl                         | one              |                       |                |                                      |
| of \           | Physic<br>this c   | ို               |   | lospital:                                  |                                   |  | A Othe             | ar: 4 □ Nui      |            | ne 5□Res                          |                  |                       | pecify)        |                                      |
| U.             | ding h   | lon              | 27. Manner of Death 1 ☑Natural 5 ☐ Pending  | 28a. Date of Injury<br>(Month, Day         | Yea <i>r)</i> 28b. Time<br>Injury |  | Bc. Injury<br>Work | :?               |            | 8d. Describe                      | how injur        | y occurred            |                |                                      |
| Division       | l or Attendi<br>after death.<br>Director: A<br>in by the fu  | ficat            | 2 Accident investigation 3 Suicide 6 Could not be   | 28e Place of Injur                         | ry - At home, farm,               | M<br>street factory                            |                    | /es 2□N          |            | 9f Location                       | (Street an       | d Number or           | Quel Q         | oute Number,                         |
| Ö              | after<br>after<br>Direct   | Certification;   | 4 Homicide determined   | building, etc.                             | . (Specify)                       | nicot, iactory                                 | , onice            |                  | 1          | City or To                        | wn, State        | )                     | nuiai n        | oute Number,                         |
|                | To the Hospitel or Attenwithin 24 hours after deat To the Funerel Director: completely filled in by the  |                  | 29a. Certifier 1 Certifying Phys  | ician: To the best of                      | f my knowledge, de                | ath occurred a                                 | at the tim         | e, date and      | d place, a | nd due to the                     | cause(s)         | and manner            | as state       | ad.                                  |
|                | n 24 i   | edical           | (Check only 2 Medical Examination)  | ner: On the basis of<br>and manner stat    | examination and/or                | investigation,                                 | in my op           | oinion, deat     | h occurre  | d at the time,                    | date and         | place, and o          | due to the     | e cause(s)                           |
|                | Mithi<br>To the  | Σ                | 29b. Signature and title of certifier   | 1/2 \                                      |                                   |  |                    | number           | _          |                                   |                  | e signed (Mo          |                |                                      |
|                | ,  |                  |   | 7  | 1/1/                              | Ĩ.   | 04                 | 345              | 3          |                                   | DEC              | EMBE                  | R 2            | 21,2005                              |
| (              | 1/   |                  | 30. Name and address of person who co   | mpiotoù cause ui ue                        | all (Item 23a) , yp               | e, Print)                                      |                    |                  |            |                                   |                  |                       |                | 21157                                |
| 5              | /  |                  | 21 Date filed (Month Day Year)  | 6-, JR                                     | MID.                              | 200  | M                  | EMO              | RIA        | LAVE                              | w                | ESTMI                 | NST            | ER, MID                              |
|                | Sta<br>Registr   |                  | 31. Date filed (Month, Day, Year)   | 32. Hegistrai                              | s Signature                       | A STAN   |                    |                  |            |                                   |                  |                       |                |                                      |
| DHI            | MH 17 Rev 1/20   | 100              | 31. Date filed (Month, Day, Year)  DEC 2 8 2005   | NA SECOND                                  | - 01                              |  |                    |                  |            |                                   | -                |                       |                |                                      |
|                |  |                  |   |  |                                   |  |                    |                  |            |                                   |                  |                       |                |                                      |

|                                |  |                         | 1 - For State Registrar   | State of Ma  | arylan                     | d / Depa                                     |   | t of H                | lealth a                   | and M      | lental Hy                              | giene                             | 15                         | +1880  |
|--------------------------------|--|-------------------------|---|--|----------------------------|--|---|-----------------------|----------------------------|------------|--|-----------------------------------|----------------------------|--|
| ı                              | Physic   | an                      | Decedent's Name (First, Middle, L   | ,  |                            |  |   |                       |                            |            | 2. Date of De<br>Month                 |                                   | Year                       | 3. Time of Death   |
|                                | /Medi  |                         | Francis Frankl  |  | r                          |  | T   |                       |                            |            | Decem                                  | ber 21,                           |                            | 12:00P M   |
|                                | Exami  | ner                     | 4a. Facility Name (If not institution, g. 15 Councilman   | •  |                            |  |   | _                     | Location                   | of Death   |  |                                   | ty of Death                |  |
|                                |  |                         |   |  | a (In use Is               | ast birthday)                                | If Under                                  | ltim                  | ore                        | 24 Hrs     | 9 Data of Dia                          |                                   | timor                      |  |
|                                | Funeral<br>Director  |                         | 217-34-8277 Usual Residence of Decedent   | 1 DXM 2 F  | 65                         | Yrs.   | Months                                    | Days                  | Hours                      | Min.       | 8. Date of Bir<br>(Month, Da<br>11/4/1 | w. <sub>Year)</sub><br>940        | 9. Birthp<br>Cour<br>Ma    | lace (State or Foreign<br>itry)<br>ryland                |
|                                | yland<br>now   |                         | 10a. State 10b. County  |  | 10c. City                  | , Town or Lo                                 | ocation                                   |                       |                            |            |  |                                   | 1                          | Od. Inside City Limits                                   |
|                                | a-fs!  | ior                     | MD Baltim   | nore   | Ва                         | ltimo:                                       | re  |                       |                            |            |  |                                   |                            | 1 ☐ Yes 2 ☑ No   |
|                                | filed within 72 hours after death with the Maryland<br>Hygiene.<br>uthar than "natural", or Itams 23a or 28a-f show<br>uth; tre Midler Examinar must be mallind at | by Funeral Director     | 10e. Street and Number<br>15 Councilman   | Avenue   |                            |  | 10f. Zip                                  | Code 212              | 06                         |            |  | 10g. Citizen o                    | What Cour                  | ntry?  |
|                                | deat   | ner                     | 11. Marital Status  | 12. Was Decedent 8<br>Armed Forces?  | er in U.S                  | S. 13.                                       | Was Deced                                 | lent of Hi            | spanic Ori                 | gin? (Spe  | ecify Yes or No<br>Rican, etc.)        | )- 14. Ra                         | ace - Ameno                |  |
| 36                             | irs after  | by Fu                   | 1 ☐ Never Married 2 📆 Married 3 ☐ Widowed 4 ☐ Divorced  |  | lo                         | 1  | 1 ☐ Yes                                   |                       | Specify:                   | i, rueno   | nican, etc.)                           | Spec                              | ack, White,<br>ify:        | nite   |
| 21215-0036                     | 2 hou  | ted                     | 15. Decedent's E  | Education  |                            | 16a. Dece                                    | dent's Usua                               | i Occupa              | ation                      |            |  | 16b. Kind of                      | Business/Inc               | dustry   |
| 215                            | be filed within 72 ho<br>ital Hygiene.<br>id othar than "natur<br>evant, ire Modiesi   | Completed               | (Specify only highest g Elementary/Secondary (0-12)   | rade completed) College (1-4or 5   | +)                         | (Give<br>life.                               | kind of wor<br>DO NOT us                  | k done d<br>e retired | luring mos<br>)            | t of worki | ng                                     |                                   |                            | ,  |
| 21                             | e filed within al Hygiene. Other than vent, the M  | Com                     | 8   | 001.090 (1.401.0   | '                          | Main   | tanan                                     | ce M                  | echar                      | ic         |  | Apartm                            | ent Co                     | omplex   |
| nd                             |  | Be                      | 17. Father's Name (First, Middle, Las   |  |                            |  |   |                       |                            |            |  | Maiden Surna                      | me)                        |  |
| yla                            |  | 70                      | Richard Bartus  |  |                            |  |   |                       | Mat                        | tie        | Howard                                 |                                   |                            |  |
| Maryland                       | C/ cg .55 15   |                         | 19a. Informant's Name/Relationship Lillian Thrash   |  |                            |  |   |                       |                            |            |  | er, City or Town                  |                            |  |
|                                | s 1 and<br>of Health<br>itam 27<br>other tr  |                         | 20a. Method of Disposition  | ier  | 20b. Pl                    |  |   |                       |                            |            | altimoj<br>ate                         | re, Mar                           |                            |  |
| Baltimore,                     | 0 0 = =  |                         | 1 😾 Burial 2 □ Cremation 3  | Removal from State   | 1                          | ace of Dispo                                 |   |                       | 9)                         |            |  |                                   | •                          |  |
| Iţi                            |  | 1                       | <ul> <li>4 □ Donation 5 □ Other (Spec</li> <li>21. Signature of Funeral Service Lice</li> </ul>   |  | Gar                        | dens (                                       |   |                       | s of Facilit               |            | 6/05                                   |                                   |                            | Maryland Home Inc.                                       |
| B                              | permit. Departr Imports any inj  |                         | 1   | 5  |                            |  | 6415                                      | Bel.                  | air R                      | oad        | Baltimo                                | ore, Ma                           | nerai<br>rvland            | 1 21206  |
|                                | cate be executed //Medical bhysician and supplied outlant the burial-transit   | Examiner                | 23a. Part1. Enter the disease, or cor shock, or heart failers. List only mediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if a.iy, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Due to (or as a Due to (or a) | a Jonseque                 | ence of):  ence of):  cross of):  cross of): | al I                                      | M                     | il (                       | 1          |  | rrest,                            |                            | Approximate Interval Between Onset and Death             |
| Vital Records, P.O. Box 68760, | law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit               | ed by Physiclan/Medical | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  Part II. Other significant conditions  | 23c. If yes, outcome 1   Live birth 4   Pregnant at 9   Unknown  | 2 Fetal ( time of de       | déath 3⊡<br>ath 5⊡                           | Ectopic pre<br>Other (spe<br>aderlying ca | ecify)                | in in Part I.              |            |  | bbacco use con                    | ntribute to th             | ny<br>Day Year<br>e cause of death?<br>ably 4 (300 known |
| eco                            | e law re<br>has bei<br>je 2 sho  | Completed               |   |  |                            |  |   |                       |                            |            | 24a. Was<br>autop                      | sv                                | Were autop                 | sy findings available                                    |
| E<br>E                         | Th<br>ate<br>pag   | Con                     |   |  |                            |  |   |                       |                            |            | perfoi<br>1 ☐ Yes                      | rmed?                             | death?                     |  |
| Vita                           | ysician: Th<br>is certificate<br>director, pag   | Be                      | 25. Was case referred to pedical examiner?  | Hospital:  |                            |  |   |                       |                            |            | (Check only o                          |                                   |                            |  |
| of                             | ys<br>di   | 2                       | 1 Yes 2 No  | 1 L Inpatier   |                            | R/Outpatien<br>28b. Time of                  |   |                       | 4 🗆 140                    |            |  | dence 6 🗆 Ot                      |                            | )  |
| on                             | ding F<br>h.<br>After<br>funera  | tlon                    | 1 atural 5 Pending  | 28a. Date of Injury<br>(Month, Day   | Year)                      | Injury                                       | M   | Bc. Injury<br>Work    | ai<br>?<br>′es 2 □ l       |            | od. Describe n                         | now injury occu                   | rrea                       |  |
| Division                       | or Attanding Physician:<br>after death.<br>Diractor: After this certific<br>in by the funeral director.  | Certification:          | 2 Accident Investigation 3 Suicide 6 Could not I 4 Homicide determined  | be Ogo Diego of Leiu   | ry - At hon<br>. (Specify) | me, farm, stre                               |   |                       | 03 201                     | -          | 8f. Location (S<br>City or Tow         |                                   | ber or Rural               | Route Number,  |
| _                              | To tha Hospital or Attanding Ph<br>within 24 hours after death.<br>To tha Funaral Diractor: After th<br>completely filled in by the funeral                        | edical C                | 29a. Certifier 1 Certifying P (Check only one) 2 Medical Exa  | hysician: To the best o<br>miner: On the basis of<br>and manner stat   | examınatı                  | rledge, death<br>on and/or inv               | occurred a restigation,                   | t the time            | e, date and<br>inion, deat | d place, a | and due to the dead at the time, o     | cause(s) and m<br>date and place, | anner as sta<br>and due to | ated.<br>the cause(s)                                    |
|                                | To th<br>within<br>To th<br>compl  | Me                      | 29b. Signature and title of certifier   |  |                            |  | 29c.                                      | License               | number                     |            | - 2                                    | 29d. Date signe                   | ed (Month, E               | Pay, Year)   |
|                                |  |                         | 1 duna  | 21Bml  | M                          |  |   | 010                   | 1797                       | >          |  | 12/2                              | 2/05                       | 7  |
|                                | $\dot{\lambda}$  |                         | 30. Name and address of person who  | completed cause of de  | ath (Item :                | 23a) (Type, I                                | Print)                                    | _                     | _                          | A          |  |                                   |                            |  |
|                                |  |                         |   | air Rua  |                            | 130  | etun                                      | nor                   | $\sim N$                   | 1 cl       | 212                                    | 36                                |                            |  |
|                                | Sta<br>Registr   |                         | 31. Date filed (Month, Day, Year)  DEC 2 8 200  | 7. Registra  | r's Signati                | ло   | K   |                       |                            |            |  |                                   |                            |  |

|                                     |  |                  | 1 - State Registrar   |                            |                                  | nd / Depa        | artment of H                                    | lealth a       | and M       | lental Hy                               |             | 05               | 41881   |
|-------------------------------------|--|------------------|---|----------------------------|----------------------------------|------------------|---|----------------|-------------|---|-------------|------------------|---|
|                                     |  |                  | 1. Decedent's Name (First, Middle, Las  | st)                        |                                  |                  |   |                |             | 2. Date of De                           | ath         | Year             | 3. Time of Death                              |
|                                     | Physici<br>/Medic  |                  | George  | William                    | Uhler,                           | Sr.              |   |                |             | Dec.                                    | 24, Day 20  |                  | ll a.m.M                                      |
|                                     | Examin   |                  | 4a. Facility Name (If not institution, give   |                            |                                  |                  | 4b. City, Town, or                              |                |             |   | 4c. Co      | unty of Death    |   |
|                                     |  |                  | 263 Cedarmer  |                            |                                  |                  | Owings  | If Under       |             | 0.0-1-10-1                              |             | Baltin           |   |
|                                     | Funeral<br>Director  |                  | 5. Social Security Number 6. S 217–16–7460  | ex<br>√M 2□F               | 7. Age (In yrs.<br>82            | Yrs.             | Months Days                                     | Hours          | Min.        | 8. Date of Birt<br>(Month, Da<br>Dec. 2 | Y 1922      | Cau              | place (State or Foreign<br>ptry)<br>laryland  |
|                                     |  |                  | Usual Residence of Decedent   |                            |                                  |                  |   |                |             |   |             |                  |   |
|                                     | how  |                  | 10a. State 10b. County  |                            | 10c. Cit                         | ty, Town or Lo   |   |                |             |   |             |                  | 10d. Inside City Limits 1 ☐ Yes 2 No          |
|                                     | Ba-f s   | cto              | Md Baltimor   | e<br>                      |                                  | Owing            | s Mills   |                |             |   |             |                  |   |
|                                     | vith th  | Director         | 10e. Street and Number  |                            |                                  |                  | 10f. Zip Code                                   |                |             |   |             | of What Cou      | intry?  |
|                                     | s 23s  | rai              | 263 Cedarmere   | Circle                     | dont Ever in II                  | 10 12            | 2111′   |                | igin? (Spe  | ody Voe or No                           |             | Race - Amer      | ican Indian                                   |
|                                     | ler de   | by Funerai       | 11. Marital Status  1 ☐ Never Married 2 Married   | Armed Ford                 | ces?                             | 1                | Was Decedent of H<br>If Yes, specify Cuba       |                |             | Rican, etc.)                            |             | Black, White     | , etc.  |
| 936                                 | urs af   | b                | 3 Widowed 4 Divorced  | If Yes, Give<br>Year or Da | WW                               | II               | 1 ☐ Yes 2 No                                    | Specify:       |             |   | Sp          | ecity: Whi       | ite   |
| Maryland 21215-0036                 | within 72 hours after death with the Maryland<br>ene.<br>than "natural", or items 23e or 28e-f show<br>ta Madigal Ezandon must be notified at  | Completed        | 15. Decedent's Ec<br>(Specify only highest gra  |                            |                                  | 16a. Dece        | dent's Usual Occup                              | ation          | st of worki | na                                      | 16b. Kind   | of Business/li   | ndustry                                       |
| 2                                   | ithin<br>or  | nple             | Elementary/Secondary (0-12)   | College (1-                | 4or 5+)                          | life.            | DO NOT use retired                              | 1)             |             |   | m,          | elephor          | ne Co   |
| 2                                   | fled w<br>flygier<br>flor th   |                  | 12 17. Father's Name (First, Middle, Last)  |                            |                                  |                  | Manager   | 18 Moth        | er's Name   | (First, Middle,                         |             |                  | ie oo.  |
| anc                                 | ntal H   | Be               | William Ande  |                            | ar                               |                  |   | to. Notin      |             | oia Bel                                 |             |                  |   |
| Ž                                   | 2 should be f<br>and Mental I<br>Is marked of<br>raumatic ave  | 2                | 19a. Informant's Name/Relationship  |                            | LCI                              | 19b. Maili       | ng Address (Street                              | and Numb       |             |   |             |                  | p Code)                                       |
|                                     | permit. Peges 1 and 2 should be filed within 72 hours after death with the Marylan Depertment of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic avent, the Mysical Examinar must be nyilled at an once. |                  | Barbara M. Uh   | ler - Wi                   | ife                              | 263              | Cedarme   | re Ci          | rcle        | , Owing                                 | s Mill      | Ls, Md.          | . 21117                                       |
| J.                                  | of Hei   |                  | 20a. Method of Disposition  | 10                         | 20b. I                           | Place of Dispo   | sition (Name of<br>matory or other place        | ce)            | 0           | Date                                    | 20c. Locat  | tion - City or T | own, State                                    |
| Ē                                   | Pege<br>nent a<br>ant: ff<br>ury or  |                  | 1 ☐ Burial 2 ⚠ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specification)   |                            | otate                            |                  | Cremator;                                       | 1              | Dec         | . 28, 2                                 | 005 Ba      | altimo           | re, Md.                                       |
| Baltimore,                          | Depenti<br>Depenti<br>Importa<br>eny ini   |                  | 21. Signature of Funeral Service Liter  | 1598                       | AR                               | 2                | Eckhard:  | ss of Facili   | eral        | Chapel                                  | . P.A.      | - 2              | 21117   |
| _                                   | <u>v</u> ∪ = 0   |                  | H.J. Col  | Maic                       | 4                                |                  | 11605 R   | eiste          | rsto        | n Rd.                                   | Owing       | gs Mill          | Approximate                                   |
| Е                                   |  |                  | 23a. Parl 1. Enter the disease, or com shock, or heart failure. List only                                   | one cause on ea            | ich line.                        | 1 1              |   |                |             |   |             |                  | Interval Between<br>Onset and Death           |
|                                     | Pnysician<br>/Medical  |                  | Immediate Cause (Final disease or condition resulting in death)   | .Arte                      |                                  |                  | ic Lard   | IOVQ           | scu         | lar D                                   | Socs        | R .              | 10 years                                      |
|                                     | Examiner   |                  |   | Due to (d                  | or as a consec                   | quence or):      |   |                |             |   |             |                  |   |
| 0                                   |  | Je               | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | b. Due to (c               | or as a consec                   | quence of):      |   |                |             |   |             | 0                |   |
| V                                   | cuted<br>nd<br>ransit  | Examiner         | that initiated events   | c                          |                                  |                  |   |                |             |   | the same    |                  |   |
| 760,                                | le be executed<br>/sicien and<br>e burial-transit  |                  | resulting in death) Last  | Due to (d                  | or as a consec                   | quence of):      |   |                |             |   |             | 1                |   |
| 6876                                | w requires that the death certificate be executed been signed by the ettending physicien and should be detached for use as the buriat-transit  | dicai            | •   | _ d                        |                                  |                  |   |                |             |   |             |                  |   |
| 9 ×                                 | ding p   | by Physician/Med | IF FEMALE:  | 23c. If yes, outo          | come of pregn                    | ancy             |   |                |             |   | 230         | I. Date of delin | re(V  |
| Bo                                  | etten<br>etten<br>for u  | cian             | 23b. Was decedent pregnant<br>in the past 12 months?<br>1 ☐ Yes 2 ☐ No                                      | 1 ☐Live bi                 | nth 2 ☐ Feta<br>ant at time of a | aldeath 3[       | ☐Ectopic pregnancy<br>☐ Other (specify)         | 1              |             |   | 200         | Month            | Day Year                                      |
| o.                                  | the d<br>by the<br>achec   | hysi             | 9 Unknown   | 9□ Unkno                   | wn                               |                  |   |                |             |   |             |                  |   |
| ις.                                 | os tha   | y P              | Part II. Other significant conditions of  | contributing to de         | ath but not re                   | sulting in the u | inderlying cause giv                            | en in Part     | 1.          | 23e. Did t                              | obacco use  | contribute to    | the cause of death?                           |
| ğ                                   | equire<br>en sly<br>ould b   |                  |   |                            |                                  |                  |   |                |             | 10'                                     | Yes 2□N     | No 3∏Pro         | bably 4 Unknown                               |
| ပ္ပ                                 | Attending Physician: The law requires that the death certificat reads.  Cleath.  Sctor: After this certificete hes been signed by the ettending phy by the funeral director, page 2 should be detached for use as the  | Completed        |   | -                          |                                  |                  |   |                |             | 24a. Was<br>autoj                       | DSV         | prior to c       | opsy findings available ompletion of cause of |
| <u>~</u>                            | The cete by page   | S                |   |                            |                                  |                  |   |                |             | 1 Yes                                   | 2 No        | death?           | 2) No   |
| <u>≅</u>                            | ician<br>certifi<br>rector   | Be               | 25. Was case referred to medical examiner?  | Hospital:                  |                                  | •                | ott   |                |             | Check only o                            |             |                  |   |
| ō                                   | Phys<br>r this<br>oral di  | 5.               | 1 X Yes 2 No<br>27. Manner of Death   | 28a. Date o                | f Injury                         | ER/Outpatie      | nt 3 DOA  | 4 L N          | ursing Ho   | me 5 Resi                               |             | Other (Spec      | ify)  |
| on                                  | nding<br>th.<br>:: Afte  | ation            | 1 Natural 5 ☐ Pending<br>2 ☐ Accident investigation   |                            | h, Day Year)                     | Injury           |   | rk?<br>Yes 2 □ | ]No         |   |             |                  |   |
| Division of Vital Records, P.O. Box | ar deg   | Certification:   | 3 ☐ Suicide 6 ☐ Could not b<br>4 ☐ Homicide determined  | 286. Place                 | of Injury - At h                 |                  | reet, factory, office                           |                |             | 28f. Location (.<br>City or To          |             | lumber or Ru     | ral Route Number,                             |
| ō                                   | ital or<br>rai Dii   |                  |   |                            | 9, 010. (0, 00.                  |                  |   |                |             |   |             |                  |   |
|                                     | To the Hospital or Attending Physicien: The lav within 24 hours effer death. To the Funeral Director: Affer this certificate hes completely filled in by the funeral director, page 2  | Medical          | (Check only 2 Madical Exam  | niner: On the ba           | sis of examin                    |                  | th occurred at the til<br>evestigation, in my o |                |             |   |             |                  |   |
|                                     | thin 2<br>of the<br>omple  | Med              | one) 29b. Signature and title of certifier  | and mann                   | ier stated.                      |                  | 29c. Licens                                     | se number      |             |   | 29d. Date s | igned (Month     | . Day, Year)                                  |
|                                     | F 3 F 8  |                  | Libert How  | W W                        | Dut                              | ,                | DIS   | 866            | 7           |   | Dar o.      | mhon             | 26,2005                                       |
| , ,                                 | : 7  |                  | 30. Name and address of person who  | completed cause            | e of death (It                   | m 23a) (Type     | Print) 1  | <u> </u>       |             |   | الإياس      | 111 2016         | -6,   |
| _                                   |  |                  | 6 Trimble Hill (  | IT. Lut                    | haru:1                           | 4/               | aryland   | 21             | 093         | •                                       |             |                  |   |
|                                     | Sta  |                  | 31. Date filed (Month, Day, Year)   |                            | egistrar's Sign                  | ature '          |   |                |             |   |             |                  |   |
|                                     | Regist   | rar              | DEC 2 8 200   | JU A                       | We will                          | 1                | 100   |                |             |   |             |                  |   |

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|                   |  |                               |  | eparage Microfile alth and Mental Hygiene 055   | 1882  |
|-------------------|--|-------------------------------|--|---|---|
|                   | Physic<br>/Medi  |                               | Decedent's Name (First, Middle, Last)  Evelyn White  | Month Day Year  | Time of Death 1:30 Pm.                      |
|                   | Examir   |                               | 4a. Facility Name (If not institution, give street and number)  8323 Mindle Circle Apt. C  Mindle  5. Social Security Number 6. Sex 7. Age (In yrs. last birthe  | 4b. City, Town, or Location of Death Windsor Mill  4c. County of Death Baltimore  |   |
|                   | Director   |                               | 078-22-3391 1□ M X□ F 98 Yr  Usuel Residence of Decedent  10a. State 10b. County 10c. City, Town of  | July 9, 1907 Mary   | (State or Foreign  Land  Inside City Limits |
|                   | h with the Ma<br>23a or 28a-f  | ai Directo                    | Maryland Baltimore Wind  100. Street and Number Mindale 8323 Mindle Circle Apt. C  | Isor Mill  10f. Zip Code  21244  USA  | 1 □Yes 2 □ No                               |
| 9036              | within 72 hours after death with the Maryland<br>ene.<br>than "natural", or Items 23a or 28a-f show<br>ha Medical Examinat must be notified at | Completed by Funeral Director | 11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 Pes 2 No If Yes, Give Year or Dates:   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  1☐ Yes 2☐ No Specify:  Specify: Blac                                      |   |
| 21215-0036        | filed within 72 h<br>Hygiene.<br>sther than "natu<br>ent, the Medical  | Completed                     | (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)  | Decedent's Usual Occupation Give kind of work done during most of working life. DO NOT use retired)  Own Home House Wife  | у   |
| Maryland          | 2 should be fill<br>and Mental Hy<br>is marked oth<br>surnatic eveni   | To Be                         | John C. Johnson  | 18. Mother's Name (First, Middle, Maiden Surname)  Rebecca Gross  Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Cod                                | de)   |
| Baltimore, Ma     | of Health<br>of Health<br>if Item 27   |                               | Grace Parker  20a. Method of Disposition  Burial 2 Cremation 3 Removal from State  83  20b. Place of Disposition Cermetery,  | Disposition (Name of crematory or other place)  Dec 27,05  Crownsville  | State                                       |
| ■ Balti           | permit. Pag<br>Department: I<br>Important: I<br>any Injury o<br>once.  |                               | 21. Signature of heral Service Icensee   | 22. Name and Address of Facility Chatman-Harris Funer 5240 Reisterstown Rd Baltimore, Md  | 21215                                       |
| 760,              | Physician and hybridal-fransit he burial-fransit   | Ical Examiner                 | 23a. Part Enter the disease, or complications that caused the death. Do not shock, or head failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of)  C. Due to (or as a consequence of)  Due to (or as a consequence of) | ropetly   | oroximate srval Between set and Death       |
| P.O. Box 68       | The law requires that the death certificat ite has been signed by the attending phyage 2 should be detached for use as the                     | Physician/Med                 | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown  23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown  | 3 Ectopic pregnancy 5 Other (specify)  23d. Date of delivery Month Day  | Year  |
|                   | w requires that the bean signed by should be detact  | þ                             | Part II. Dther significant conditions contributing to death but not resulting in the   | he underlying cause given in Part I.  23e. Did tobacco use contribute to the ca   |   |
| of Vital Records, |  | Completed                     | 6) magurosis   | 24a. Was an autopsy find to complet death?  1 Yes 2 No 1 Yes 2  |   |
| Division of Vit   | or Attending Physiter death.<br>Director: After this<br>in by the funeral dir  | Certification; To Be          | 25. Was case referred to medical examiner?  1  | ne of ury M 28c. Injury at Work?  M 28d. Describe how injury occurred   | ste Number,                                 |
| _                 | To the Hospitel or Atten within 24 hours after deat To the Funaral Director: completely filled in by the                                       | Medical Ce                    | 29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, decrease of examination and/or and manner stated.  | death occurred at the time, date and place, and due to the cause(s) and manner as stated, or investigation, in my opinion, death occurred at the time, date and place, and due to the d | cause(s)                                    |
|                   | To t<br>Withi  | Z                             | 29b. Signature and title of certifier  1   | 29c. License number 29d. Date signed (Month, Day,   | Year)                                       |
| Ž.                | Sta<br>Registr   |                               | 31. Date filed (Month, Day, Year)  DEC 2 8 2005  | Sol   | 17120.                                      |

|  | Certificate of Death Reg. No. 05 4 1883  |
|--|--|
| Physician<br>/Medical  | 1. Decedent's Name (First, Middle, Lest)  VIOLETTA WADE  2. Date of Death Month Day Year Z 1 2005 7.45 A   |
| Examiner Funeral Director  | 4e Facility Name (If not institution, give street and number)  1. And County of Death  2. County of Death  3. And Translate Crit.  5. Social Security Number  2. Social Security Number  2. Social Security Number  3. Social Security Number  4. County of Death  3. And Translate Crit.  4. County of Death  3. And Translate Crit.  4. County of Death  3. And Translate Crit.  4. County of Death  3. And Translate Crit.  4. County of Death  3. And Translate Crit.  4. County of Death  3. And Translate Crit.  4. County of Death  3. And Translate Crit.  4. County of Death  3. And Translate Crit.  4. County of Death  3. And Translate Crit.  4. County of Death  3. And Translate Crit.  4. County of Death  3. Date of Birth (Month, Day, Yeer)  4. County of Death  3. And Translate Crit.  4. County of Death  3. And Translate Crit.  4. County of Death  3. And Translate Crit.  4. County of Death  3. And Translate Crit.  4. County of Death  3. And Translate Crit.  4. County of Death  3. And Translate Crit.  4. County of Death  3. And Translate Crit.  4. County of Death  3. And Translate Crit.  4. County of Death  3. And Translate Crit.  4. County of Death  3. And Translate Crit.  4. County of Death  3. And Translate Crit.  4. County of Death  3. And Translate Crit.  4. County of Death  3. And Translate Crit.  4. County of Death  3. And Translate Crit.  4. County of Death  4. County of D |
| Maryland -f show fled at   | Usual Residence of Decedent           10a. State         10b. County         10c. City, Town or Location         10d. Inside City Limit           MD         N/A         BALTIMORE CITY         1 Xyes 2 N   |
| after death with the Mar<br>in ferms 23a or 28a-f si<br>ciner mast be notified<br>Funeral Director   | 10e. Street end Number 2759 RAYNOR AVENUE 10f. Zip Code 21216 USA  |
| d 2 should be filed within 72 hours after death with the Maryland and Mental Hygiene.  7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner mast be motified at To Be Completed by Funeral Director  | 11. Marital Status  12. Was Decedent Ever in U,S. Armed Forces?  1  Never Married 2 Married XXXWidowed 4 Divorced  12. Was Decedent Ever in U,S. Armed Forces?  1  Yes 2 No If Yes, specify:  13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  14. Race - American Indian, Black, White, etc.  1  Yes 2 No Specify: Specify: BLACK   |
| led within 72 hours a lygiene. The than "natural", o nt, tre Medical Evan Completed by   | 15. Decedent's Education (Specify only highest grede completed)  Elementary/Secondary (0-12)  1 2 T H  16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)  DOMESTIC  16b. Kind of Business/Industry  16b. Kind of Business/Industry  PRIVATE FAMILIES   |
| ould be filed Mental Hyg arked other atic event,   | 17. Father's Neme (First, Middle, Last)  18. Mother's Name (First, Middle, Maiden Sumame)  JOHN BUNNING  BLANCHE BRIGGS  |
| if Health end Nitem 27 is maintenance other trauma   | 19a. Informant's Name/Relationship (Type, Print)  CHARLES L. BROWN / SON  19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code)  4014 SPRUCE DRIVE, BALTIMORE, MD 21215  |
| Department of Health e<br>Important: If item 27 is<br>any injury or other tra<br>once.   | 20a. Method of Disposition  1 M Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)  20b. Place of Disposition (Neme of cemetery, crematory or other place)  ARBUTUS MEMORIAL PK. Date  12/28/05 BALTIMORE CO,  |
| Import<br>any in   | 21. Signature of Funeral Service Licensee 22. Name and Address of Facility HOWELL FUNERAL HOME 21207 4600 LIBERTY HEIGHTS AVE., BALTIMORE,   |
| Attending Projectant: The law requires that the cearn certificate be executed to the control of the certificate hes been signed by the attending physician end by the funeral director, page 2 should be detached for use as the buriel-trensit and be completed by Physician/Medical Examiner | 23a. Part 1. Enter the disease, or complications the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause of each line.  Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):   |
| by the attertached for the hysicial  | Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I.  23b. Did tobecco use contribute to the cause of death  1 Yes 2 No 3 Probably 4 Vinkno  |
| cate hes been signed by the attending page 2 should be detached for use Completed by Physician/  | 24a. Was an autopsy performed?  24b. Were autopsy findings available prior to completion of cause of death?  |
| scian: The lay certificate hes irector, page 2  Be Comp  | 25. Was case referred to medical examiner?  1 Yes 2 No  |
| الم الم الم  | 1   Yes 2   No   |
| To the Hospital within 24 hours To the Funeral completely filled Medical Co  | 29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) and manner as stated.  Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) and manner stated.   |
| To the comp  | 29b. Signature and title of certifier  ATTENDING  29c. License number  29d. Date signed (Month, Day, Year)  DED 5-69-48  DEC 21 2005   |
| Ŋ  | ATTENDING DEO 5-69 48 DEZ 21 2005  30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print)  TANSINDA 300 MENORY PLACE & ITE 3+1 BATIMORE  |
| State  | 31. Date filed (Month, Day Year)  32. Pegistrer's Signature  |

|              |   |                  | 1 - For<br>State<br>Registrar  |  | Maryland / D                         | epartmer<br>Certifica              |                               |                                      |                                      | Reg! No.                             | 05                                 | 41884  |
|--------------|---|------------------|--|--|--------------------------------------|------------------------------------|-------------------------------|--------------------------------------|--------------------------------------|--------------------------------------|------------------------------------|--|
|              | Physici   | an               | Decedent's Name (First, Middle   |  |                                      |                                    |                               |                                      | 2. Date of De<br>Month               | aath<br>Day                          | Year                               | 3. Time of Death                                   |
|              | /Medic  | al               | 4a. Facility Name (If not institution  |  | vin C Will                           |                                    | Town and                      |                                      | Decembe                              |                                      | 2005                               | 1709 PM  |
|              | Examin  | er               | NORTHWEST  | Medical  | Center                               |                                    |                               | LLS to                               |                                      |                                      | ounty of Death                     | n 0 e  |
|              | Funeral   |                  | 5. Social Security Number  |  | Age (In yrs. last birt               | hday) If Unde                      | r 1 Year                      | If Under 24 Hrs                      | 8. Date of Bir                       | th                                   |                                    | place (State or Foreign                            |
|              | Director  |                  | 216-52-7397  | 1 🔀 M 2 🗆 F                                      | 55                                   | rs. Months                         | Days                          | Hours Min                            |                                      | i <i>y, Year)</i><br>I <b>, 1950</b> |                                    | ntry)<br>Maryland                                  |
|              | pu ,  |                  | Usual Residence of Decedent  10a, State 10b, County  |  | 140 Ot T                             |                                    |                               |                                      |                                      |                                      |                                    |  |
|              | shov  | 5                | ,  | Baltimore  | 10c. City, Town                      | or Location                        |                               |                                      |                                      |                                      |                                    | 10d. Inside City Limits<br>1 ☐ Yes 2 X No          |
|              | 28a-f   | ect              | 10e. Street and Number   | Daitimore  |                                      | 104 7                              | Code                          |                                      |                                      | 10g Citizo                           | n of What Cou                      | `  |
|              | with with   | Ö                | 8480 Carlson Lane  |  |                                      | 101. 21                            | 0000                          | 21244                                | 1                                    | TOG. CITIZO                          | U.S.                               | ,  |
|              | within 72 hours after death with the Maryland<br>ene.<br>than 'natural', or Items 23a or 28a-f show<br>fra Madical Examiner must be notified at   | Funeral Director | 11. Marital Status   | 12. Was Decede                                   |                                      | 13. Was Dece                       | dent of His                   |                                      | Specify Yes or No<br>to Rican, etc.) | )- 14                                | Race - Ameri                       | can Indian,  |
| စ္           | or Ite  |                  | 1 ☐ Never Married 2 ☐ Marr   | Armed Force                                      |                                      | If Yes, spe                        |                               |                                      | rto Rican, etc.)                     |                                      | Black, White,                      | etc.   |
| 21215-0036   | ural.   | Completed by     | 3 Widowed 4 Divorced   | If Yes, Give<br>Year or Date                     | s:                                   | 1 165                              | ZLXNO                         | Specify:                             |                                      | S                                    | pecify:                            | Black  |
| 5-           | "natu   | lete             | 15. Deceden<br>(Specify only higher  |  | 16a.                                 | Decedent's Usu<br>(Give kind of wo | rk done du                    |                                      | orking                               | 16b. Kind                            | of Business/In                     | dustry   |
| 12           | withir<br>ene.<br>than  | ш                | Elementary/Secondary (0-12)  | College (1-4                                     | or 5+)                               | life. DO NOT i                     |                               | rvisor                               |                                      | F                                    | Recreation                         | & Parks  |
| 0<br>0       | filed<br>Hygi<br>other<br>ent, I  | a                | 17. Father's Name (First, Middle,  | Last)  |                                      |                                    | -                             |                                      | me (First, Middle                    | , Maiden Si                          | umame)                             |  |
| <u>la</u> n  | lid be<br>lental<br>ked<br>ic ev  | To B             | Jam  | es Williams                                      |                                      |                                    |                               |                                      | Na                                   | omi Fa                               | irley                              |  |
| Maryland     | permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at anone. |                  | 19a. Informant's Name/Relations  | hip (Type, Print)                                | 19b.                                 | Mailing Address                    | s (Street an                  | d Number or R                        | ural Route Numb                      | er, City or 7                        | own, State, Zip                    | Code)  |
| Σ            | and 2<br>saith<br>n 27 i  |                  | Christine B Williams   | Wife   |                                      | 8406 Ca                            | rlson La                      | ne Windso                            | or Mills, Man                        | yland 21                             | 244                                |  |
| ore          | of He   |                  | 20a. Method of Disposition  1 🗷 Burial 🔎 🗋 Cremation   | 3 Demoval from Sta                               | cometen                              | Disposition (Na<br>, crematory or  | me of<br>other place)         |                                      | Date                                 | 20c. Loca                            | tion - City or To                  | own, State   |
| Ĕ            | Pag<br>ment<br>ant: I   |                  | '4 □ Donation 5 □ Other (S   | pecity)  |                                      | (ing"s Merr                        | orial Pa                      | ark                                  | 12/27/05                             |                                      | Woodlaw                            | n, Md  |
| Baltimore,   | Depart<br>Import<br>Import<br>Injort<br>Injort<br>Injort  |                  | 21. Signature of Funeral Service   | Licensee   |                                      | 22. Name a                         |                               |                                      | Changl D C                           |                                      |                                    |  |
|              | GD 2 8 0  |                  | So Part Est In Asset   | piller   | and the death Dec                    | 16                                 | 39 Nor                        | th Broadwa                           | Chapel P.C<br>ay Baltimore           | - Maryl                              | and 21213                          |  |
| j.           |   |                  |  | only one cause on each                           | h line.                              | ot autai ma moi                    | ie ot dying,                  | such as cardia                       | c or respiratory a                   | rrest,                               |                                    | Approximate<br>Interval Between<br>Onset and Death |
|              | Physician<br>/Medical   |                  | firmediate Chuse (Fina)<br>disease or condition<br>resulting in death)                               | _a 500   | SFIRALORG                            | 1 tai                              | LURE                          |                                      |                                      |                                      |                                    | days   |
| П            | Examiner  |                  |  | Due to (or                                       | as a consequence                     | f):                                |                               |                                      |                                      |                                      |                                    | dance  |
|              |   | F.               | Sequentially list conditions,  | D  | all a consequence of                 | 0:                                 |                               |                                      |                                      |                                      | -                                  | augs   |
|              | uted<br>d<br>ansit  | min              | Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events |  |                                      | ,                                  |                               |                                      |                                      |                                      |                                    |  |
| ó            | exection and and rial-tra   | Еха              | resulting in death) Last   | Due to (or                                       | as a consequence o                   | f):                                |                               |                                      |                                      |                                      |                                    |  |
| 8760,        | death certificate be executed<br>e attending physician and<br>nd for use as the burial-transit  | dical Examiner   |  | d  |                                      |                                    |                               |                                      |                                      |                                      |                                    |  |
| 9            | ng ph<br>a as th  |                  | IF FEMALE:   |  |                                      |                                    |                               |                                      |                                      |                                      |                                    |  |
| Вох          | ath ce<br>ttend<br>or use   | lan/             | 23b. Was decedent pregnant in the past 12 months?  |  | 2 Fetel death                        | 3 □Ectopic p                       |                               |                                      |                                      | 230                                  | d. Date of delive<br>Month         | ery<br>Day Year                                    |
| 0.           | ō o o   | by Physician/Me  | 1 Yes 2 No   | 4□Pregnan<br>9□Unknowr                           | t at time of death                   | 5 Other (s                         | oecify)                       |                                      |                                      |                                      | WORK                               | Day 19al   |
| Δ,           | that the  | Ph               | Part II. Other significant condition   | ons contributing to deat                         | h but not resulting in               | the underlying of                  | ause diven                    | in Part I.                           | 23e. Did t                           | obacco use                           | contribute to the                  | he cause of death?                                 |
| ds,          | es<br>be  |                  | Ů  | 3  | <b>3</b>                             |                                    | ,                             |                                      |                                      | Yes 2 1                              |                                    |  |
| Vital Record | w requir<br>been si<br>should   | Completed        |  |  |                                      |                                    |                               |                                      | 24a. Was                             | an s                                 | 24h Were auto                      | psy findings available                             |
| Re           | The law<br>ite has b  | duic             |  |  |                                      |                                    |                               |                                      | autor<br>perfo                       | rmed?                                | prior to co                        | mpletion of cause of                               |
| tal          |   | a)               | 25. Was case referred to medical   |  |                                      |                                    |                               | 26 Place of De                       | 1 ☐ Yes<br>ath (Check only o         | 2 No                                 | 1 🗆 Yes                            | 2 No   |
| >            | Physician:<br>rthis certific<br>ral director,   | To B             | examiner?  | Hospital:  | atient 2 ER/Out                      | patient 3 D                        | Other                         |                                      | Home 5 Resid                         |                                      | Other (Specif                      | iv)  |
| 0            | <u>a</u> = e  |                  | 27. Manner of Death  | 28a. Date of I                                   | njury 28b. Ti                        |                                    | 28c. Injury a<br>Work?        | ıt                                   | 28d. Describe                        |                                      |                                    | 77   |
| ior          | ttendin<br>death.<br>ctor: Afi<br>y the fur   | atio             | 1 XNatural 5 ☐ Pendin<br>2 ☐ Accident investig   | pation   | Day roar)                            | M                                  |                               | s 2 No                               |                                      |                                      |                                    |  |
| Division of  | I or Attence<br>after death<br>Director:<br>I in by the   | Certification:   | 3 Suicide 6 Could r<br>4 Homicide determ   | ined 286. Place of                               | Injury - At home, far etc. (Specify) | m, street, factor                  | y, office                     |                                      | 28f. Location (S<br>City or Tox      | Street and N                         | lumber or Rura                     | Il Route Number,                                   |
|              | ital or af  |                  |  |  |                                      |                                    |                               |                                      |                                      |                                      |                                    |  |
|              | To the Hospital or Attending Phwithin 24 hours after death. To the Funeral Director: After th completely filled in by the funeral   | edical           | 29a. Certifier 1 Certifyin (Check only one) 2 Medicel  | g Physicien: To the be<br>Exeminer: On the basis | s of examination and                 | death occurred<br>or investigation | at the time,<br>i, in my opir | , date and place<br>nion, death occi | e, and due to the urred at the time, | cause(s) an<br>date and pl           | id manner as si<br>ace, and due to | tated.<br>the cause(s)                             |
|              | To the within 2 To the comple   | Mec              | 29b. Signature and title of certifier  | and manner                                       | stated.                              | 29                                 | c. License r                  | number                               |                                      | 29d. Date s                          | igned (Month,                      | Dav Year)  |
| 1            | H 3 F 8   |                  |  | 1/ lun   | XN                                   |                                    | 1)                            | 7777                                 |                                      |                                      |                                    | 26, 2005   |
| 1            | 9   |                  | 30. Name and address of person   | who completed cause of                           | of death (Item 23a)                  | Type, Print)                       | 1 -                           | 7 / 7                                |                                      |                                      |                                    | 1 000  |
| 1            | 1   |                  | <i>C</i> -   | MAVI 1   | 1                                    | tC , 1                             | (AT                           | 10.40                                | 2113                                 | 2                                    |                                    |  |
|              | Sta   | _                | 31. Date filed (Month, Day, Year)  | 32. egi  | istrar's Signature                   | 4 .                                |                               |                                      |                                      |                                      |                                    |  |
|              | Registr   | ar               | QEC 2 8  | 2005   | was the                              | 130 C                              | •                             |                                      |                                      |                                      |                                    |  |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene = State Registrar Reg No.U U 5 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Month December 14,2005 Dorothy E. Wenger 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Havre I Year lf Under 24 Hrs. 8. ( itizens Home ursing Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth Birthplace (State or Foreign Country) 1□M 2XF Days Hours Min. 187-09-9413 07/20/1919 Pennsylvania Usual Residence of Decedent 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits 1 Yes 2 □ No Harford Havre de Grace 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1715 Chapel Road 21078 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 💢 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 6th Homemaker Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) George Schrack Ella Nora Miller 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charlotte T. Patrone- Admin. 1026 Adcock Road, Lutherville, MD 21093 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) R.A. Ferris & Co. 12/19/05 West Chester, PA Mitchell-Smith Funeral Home, P.A. 21. Signature of Funeral Service Licensee 123 S. Washington, Havre de Grace, MD 21078 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Carcinoma Lears Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Under vin Due to (or as a consequence of): Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably JUnknown ,24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an autopsy 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28d. Describe how injury occurred 5 Pending investigation 1 Matural 1 ☐ Yes 2 ☐ No 2 Accident

attending physician and for use as the burial-transit Physician/Medical To the Hospitel or Attendi within 24 hours after death. To the Funerel Director: A

Wenger, Dorothy

**Physician** 

/Medical

Director

Funerai

þ

MD

Examiner

**Funeral** 

Director

item 27 is marked other than "natural", or itams 23a or 28a-f show other treumstic event, the Medical Examinar must be recitified at

permit. Pages 1 and 2 should be flied within 72 hours after c Department of Heelih and Mental Hygiene. Importent: If Item 27 Is marked other than "natural", or Itam any injury or other treumetic event. Its Mudical Exercition. Once.

**Physician** 

/Medical

Examiner

3altimore, Maryland 21215-0036

the Maryland

death

Completed Certification: To Be

0

1 Descritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier

6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29c. License number D-15994 29d. Date signed (Month, Day, Year)

12-15-05

30. Name and address of push n who completed cause of death (Item 23a) (Type, Print)

S. LUNION AVE, HAVRE OF GRACE MD 21078 S. GALVEZ 625 32. Registrar's Skrhature

State Registrar

3 Suicide

29a, Certifier (Check only one)

4 Momicide

DHMH 17 Rev 1/2001

Registrar

DEC 2 8 2005

| 9          |  |                  | 1- For State Registrar   | State of Maryland / Dep  |  | Mental Hygie   | 3  |
|------------|--|------------------|--|--|--|--|--|
| J. way     | Physic<br>/Medi<br>Examir  | cal              | Decedent's Name (First, Middle, Last)     Sylvia A. Washi      A. Fecility Name (If not institution, give s  | ington   | 4b. City, Town, or Location of De  | 2. Date of Death Month December                      | Day Year 25 2005 3. Time of Death 1:20p M  |
|            | Funeral<br>Director  |                  | Carroll Hospital  5. Social Security Number 231-54-8416  6. Sex  | Center   | Westminster  | rs. 8. Date of Birth                                 | Carroll  9. Birthplace (State or Foreign Country)  |
|            | death with the Maryland<br>me 23a or 28a-f show  | ector            | 10a. State 10b. County Md Carroll  | 10c. City, Town or L<br>Sykesvil   | le   |  | 10d. Inside City Limits<br>1 \( \overline{\text{Y}} \end{align* Yes 2 \( \overline{\text{No}} \) |
|            | 23s or 2   | Funeral Director | 7423 Village Rd.   | Apt 10   | 10f. Zip Code<br>21784   | 10g  | . Citizen of What Country? USA   |
|            | be filed within 72 hours after death with the Marylan Ital Hygiene. Id other then "neturel", or tieme 23a or 28a-f show event, the Medical Evandar ment to redified at   | þ                | 11. Marital Status 1  1 Never Married 2 Married 3 Widowed 4 Divorced   | 2. Was Decedent Ever in U.S. Armed Forces? 1   | Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pur 1 ☐ Yes 2 ☐ No Specify:                 | (Specify Yes or No-<br>erto Rican, etc.)             | 14. Race - American Indian, Black, White, etc.  Specify: black                                   |
| 0-6121     | within 72 ho<br>ene.<br>then "netur<br>he Medical I  | Completed        | 15. Decedent's Educ<br>(Specify only highest grade<br>Elementary/Secondary (0-12)  | College (1-4or 5+) (Give   | edent's Usual Occupation<br>9 kind of work done during most of w<br>DO NOT use retired)<br>ealth care worker | rorking  | b. Kind of Business/Industry  State Of Maryland  |
| ⊆          | D 2 2 0  | To Be Co         | 17. Father's Name (First, Middle, Last) Haywood Washing  | ;ton   | 18. Mother's N<br>Tralic   | ame <i>(First, Middle, M</i> ai<br>e Dixon           | iden Sumame)   |
| _          | 27 Ich   |                  | 19a. Informant's Name/Relationship (Typ. Charles Washington  |  | ing Address (Street and Number or .<br>Aspen St. NW, Wa  |  |  |
| Baltimore, | permit. Pages 1 a<br>Department of Hes<br>Important: If Item<br>any Injury or othe<br>once.  |                  | 20a. Method of Disposition 1 ₩ Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)  | Lake Vie   | 1  | 31-05 Sy   | c. Location - City or Town, State<br>vkesville, Md   |
| n<br>n     | Departition Depart | į                | 21. Signature of Funeral Service License  Page Haight S  | Herbert P  | <ul><li>2. Name and Address of Facility H</li><li>.0. Box 195 Syke</li></ul>                                 | aight Funer<br>sville, Md                            | cal Home & Chapel<br>21784   |
|            | Physician /Medical Examiner  | Examiner         | 23a. Part1. Enter the disease, or complic shock, or heart failure. List only one immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | Due to (or as a consequence of):  Due to (or as a consequence of):   | Asthmatic  |  | Approximate Interval Between Onset and Death  Hominute   |
| -          | 0 0  | cal              | d.  IF FEMALE:   | ic. If yes, outcome of pregnancy   |  |  |  |
|            | it the death<br>by the atter<br>tached for u   | Physician/Med    | 23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No 9  Unknown  | 1☐Live birth 2☐Fetel death 3[  | □Ectopic pregnancy □ Other (specify)   |  | 23d. Date of delivery  Month Day Year  |
| cords, r   | Ine law requires that the death certifical<br>ate has been signed by the attending phy<br>page 2 should be detached for use as th  | by               | Part II. Other significent conditions cont   | ributing to death but not resulting in the unit roctive Pulmo  |  |  | co use contribute to the cause of death?   |
| ומו שבי    | To the rospital or Attending Prhysicien: The law requires that the death within 24 hours after death. Within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending the funeral director, page 2 should be detached for completely filled in by the funeral director, page 2 should be detached for  | e Completed      | 25. Was case referred to medical   |  | 26 Place of D  | 24a. Was an autopsy performed 1 Yes 2 2 3            |  |
| 5          | nysici<br>his cer<br>I direc   | To B             | examiner? Yes 2 No   | ospital: 1 Inpatient ER/Outpatien  | Other  |  | e 6 ☐Other (Specify)   |
| 5          | th.<br>: After t<br>funera   | tion:            | 27. Manner of Death  1 Natural 5 Pending 2 Accident investigation  | 28a. Date of Injury<br>(Month, Day Year) 28b. Time o   | f 28c. Injury at Work?  M 1 ☐ Yes 2 ☐ No   | 28d. Describe how i                                  | njury occurred   |
|            | ital or Atter rs after dea al Director led in by the   | Certification:   | 3 Suicide 6 Could not be determined  | 28e. Place of Injury - At home, larm, str<br>building, etc. (Specify)                                      | reet, factory, office  | 28f. Location (Stree<br>City or Town, S              | t and Number or Rural Route Number,<br>tate)   |
| :          | o fost   | Medical          | 29a. Certifier (Check only one)  | cian: To the best of my knowledge, deat<br>er: On the basis of examination and/or in<br>and manner stated. | h occurred at the time, date and place vestigation, in my opinion, death occ                                 | ce, and due to the cause<br>curred at the time, date | e(s) and manner as stated.<br>and place, and due to the cause(s)                                 |
| , '        | vithi<br>To the  | Ž                | 29b. Signature and title of certifier  | LO- UN DW  | 29c. License number  |  | Date signed (Month, Day, Year)   |
|            | dy   |                  | 30. Name and address of person who com   | npleted ca se of death (Item 23a) (Type,   | Print) Print) Print)   | net F  | 2-27-2005<br>Edenik MD 21701   |
| 2.         | Sta<br>Registr   |                  | 31. Date filed (Month, Day), Year)   | 32 registrar's Signature   | and a  | i pe   | Merica I'V ALICI   |

|                |  |   | 1 - For<br>State<br>Registrar   | State of Ma   |                                      | artment of<br>rtificate of              |                                      | nd Mental Hygi  | ene<br>2.005                                 | 41888   |
|----------------|--|---|---|---|--------------------------------------|---|--------------------------------------|---|--|---|
|                | Physici  | ian   | Decedent's Name (First, Middle, Last  |   |                                      |   |                                      | 2. Date of Death<br>Month                             | Day Year                                     | 3. Time of Death                              |
|                | /Medi  | cal   | Evelyn T.   | Williams  | on                                   |   |                                      | Decembe   | r 21, 2005                                   | 12:00 P M                                     |
|                | Examir   | ner   | 4a. Facility Name (If not institution, give Wilson Health Car   | ·   |                                      | _                                       | , or Location of I<br>hersbur        |   | 4c. County of Deat                           |   |
|                | Funeral  | _   | 5. Social Security Number 6. Se   |   | (In yrs. last birthday)              | If Under 1 Yea                          | ır   If Under 24                     | 0   |  |   |
|                | Director   |   | 467 <b>-</b> 03 <b>-</b> 1995   | ]M 2█F  | 93 Yrs.                              | Months Day                              | s Hours                              | Min. 8. Date of Birth (Month, Day, November 1         | <sup>Year)</sup> 1912 Τ                      | hplace (State or Foreign<br>untry)<br>Cexas   |
|                | put 🖈  |   | Usual Residence of Decedent  10a, State 10b, County   |   | 10c. City, Town or Lo                | nation                                  |                                      |   |  | 10d. Inside City Limits                       |
|                | Maryla<br>f sho  | ៦   | Maryland Montgom  | ery   | Gaither                              |   |                                      |   |  | 1 X Yes 2 □ No                                |
|                | 28a-   | rect  | 10e. Street and Number  |   |                                      | 10f. Zip Code                           | 1                                    | 10  | g. Citizen of What Co                        | untry?  |
|                | th with  | a D   | 415 Russell Avenue  | #104  |                                      | 2087                                    | 7                                    |   | United St                                    | ates  |
|                | 72 hours after death with the Maryland<br>natural', or Itema 23a or 28a-f show<br>cleal Examiras must be rectified at  | Funeral Director                            | 11. Marital Status  | 12. Was Decedent E<br>Armed Forces?                       | Ever in U.S. 13.                     | Was Decedent of                         | f Hispanic Origin                    | n? (Specify Yes or No-<br>Puerto Rican, etc.)         | 14. Race - Ame<br>Black, White               |   |
| 36             | s afte   | by Fu                                       | 1 ☐ Never Married 2 ☐ Married 3 🔀 Widowed 4 ☐ Divorced  | 1 ☐ Yes 2 🔀 N<br>If Yes, Give                             | io                                   | 1 ☐ Yes 2 🔀 N                           |                                      | 30.10 / 110.11, 310.1                                 |  | ite   |
| 21215-0036     | tural  | ed b  | 15. Decedent's Edu  | Year or Dates:  | 16a Dece                             | dent's Usual Occ                        | upation                              | 1   | 6b. Kind of Business/                        |   |
| 215            | nin 72<br>In "ne   | plet  | (Specify only highest grad Elementary/Secondary (0-12)  | e completed) College (1-4or 5-                            | (Give                                | kind of work don<br>DO NOT use retir    | e during most o                      | f working '   | OD. KING OF BUSINESS                         | industry                                      |
| 21             | filed within<br>Hygiene.<br>Ither than "   | Completed                                   | Libition lary cocondary (0-12)  | 4   |                                      | nomic C                                 | onsulta:                             | nt  | County Go                                    | vernment                                      |
| nd             | be file<br>d oth   | Be  | 17. Father's Name (First, Middle, Last)   |   |                                      |   |                                      | Name (First, Middle, M                                | laiden Surname)                              |   |
| yla            | 1.2 should be filed within n and Mental Hygiene. 7 is marked other than "traumatic event, traumatic  | 2   | Edward Troell   |   |                                      |   |                                      | a Schulze   |  |   |
| Maryland       | s 1 and 2 should be filed within 72 hours after death with the Marylan I Health and Mental Hygiene. Item 27 Is marked other than "natural", or Itema 23a or 28a-f show item 27 Is marked other than "natural", or Itema 21a or 28a-f show other traumatic event, if a Medical Examinar must be notified at   |   | 19a. Informant's Name/Relationship (T)  Karen Williamson  |   |                                      |   |                                      | or Rural Route Number,<br>.W., Washing                |  |   |
|                | of Health<br>item 27<br>other tr   |   | 20a. Method of Disposition  |   | 20b. Place of Dispo                  | sition (Name of                         | 1                                    | Date 2  | Oc. Location - City or                       |   |
| E              | 00   |   | 1 ☐ Burial 2 🖾 Cremation 3 ☐ F  1 ☐ Donation 5 ☐ Other (Specify)  |   | Monts<br>Cremate                     | natory or other pl<br>comery<br>rium, I | nc. De                               | cember 24,<br>2005                                    | Bethesda,                                    | Marvland                                      |
| Baltimore,     | arth arth inju   |   | 21. Signatu s of Funer J Simile Licens  |   |                                      |   |                                      |   |  |   |
| <u> </u>       | Dep Impo   |   | Mundanen  | MO  | 1420 3                               | 00 West Mc                              | ontgomery                            | Avenue, Rock  | ville, Maryl                                 | Inc.<br>and 20850–2805                        |
| 8760,          | Physician /Medical Examiner the private reason the private reason to the private reason  | lical Examiner                              | Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, I any Jeeling to Immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | Due to for as a  Due to for as a  Due to for as a         | a consequence of):                   | nie                                     | eelu                                 | se .  |  | Onset and Death                               |
| .O. Box 6      | The law requires that the death certificate be executed the has been signed by the attending physiclen and tage 2 should be detached for use as the burial-transit   | Physician/Medical                           | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown   | 3c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at t | 2 ☐ Fetal death 3 ☐                  | Ectopic pregnan                         | су                                   |   | 23d. Date of deliment                        | very<br>Day Year                              |
| ο,             | es that<br>igned b   | by PI                                       | Part II. Other significant conditions con   | ntributing to death bu                                    | t not resulting in the un            | nderlying cause g                       | iven in Part I.                      | 23e. Did toba   | cco use contribute to                        | the cause of death?                           |
| Vital Records, | equire<br>en siç<br>ould b   |   | unneouse  | num   | e fuers                              | umi                                     | ydis                                 | 1 Yes   | 2 □No 3 □ Pro                                | bably 4 Unknown                               |
| ec             | e law rec<br>has bee   | Completed                                   | Typercent   | m, UX   | reeja                                | con                                     |                                      | 24a. Was an autopsy                                   | prior to c                                   | opsy findings available ompletion of cause of |
| E E            |  |   | Spinalste   | nsice   | c. Atas                              | cia, b                                  | Jemen                                | tea 1□ Yes 2[   | ed? death?<br>PNo 1 ☐ Yes                    | 2 🗆 No  |
| ξ.             | 5 69 F   | o Be  | 25. Wis case referred to medical examiner?  | lospital:   |                                      |   | thor /                               | Death Check onl one                                   |  |   |
| of             |  | <u>                                    </u> | 1 Yes 2 No  | 28a. Date of Injury                                       | 28b. Time of                         | t 3L DOA                                | 4 Mursi                              | ng Home 5 Residen<br>28d. Describe how                |  | ify)  |
| ion            | 를 를 를 들는<br>다 를 들는 다 하는 다 다 다 다 다 다 다 다 다 다 다 다 다 다 다 다 다  | atio  | 1 ☑Natural 5 ☐ Pending<br>2 ☐ Accident investigation  | (Month, Day   | Year) Injury                         |   | ork?<br>⊒Yes 2.⊟No                   |   |  |   |
| Division       | I or Atten<br>after deat<br>Director:<br>I in by the   | Certification;                              | 3 Suicide 6 Could not be determined   | 28e. Place of Injur-<br>building, etc.                    | ry - At home, farm, str<br>(Specify) | eet, factory, office                    | )                                    | 28f. Location (Stre<br>City or Town,                  | et and Number or Rui<br>State)               | al Route Number,                              |
| Ω              | oltal o<br>urs aft<br>arai DI  |   |   | 1   |                                      |   |                                      | A. C.   |  |   |
|                | To the Hospital or At within 24 hours after of the Funeral Director the Funeral Director the Funeral Director the Funeral Director the Funeral Director the Funeral Director the Funeral Director the Funeral Director the Funeral Director the Post Tributation of the Post T | edical                                      | 29a. Certifier (Check only one)  1 Certifying Physical Examination  | ner: On the basis of and manner state                     | examination and/or inv               | occurred at the trestigation, in my     | time, date and p<br>opinion, death o | lace, and due to the cau<br>occurred at the time, dat | ise(s) and manner as<br>e and place, and due | stated.<br>to the cause(s)                    |
|                | To the H<br>within 24<br>To the F<br>complete  | Me  | 29b. Signature and title of certifier   | and marrier state   | 00.                                  | 29c. Licen                              | nse number                           | 290   | d. Date signed (Month)                       | Day, Year)                                    |
| )              | 1  |   | 1 / Robert  | Bisch.  | balus                                | D04                                     | 4115                                 | 2   | cember                                       | 21,2005                                       |
| 10             | 1  |   | 30. Name and address of person who co<br>H. Robert Birschb  |   |                                      |   | ue, Gai                              | thersburg,  |  | 20877   |
|                | Sta<br>Regístr   | - 1   | 31. Date filed (Month, Day, Year)<br>DEC 2 8  | 32. Registrat   |                                      | book                                    |                                      |   |  |   |

|                   |  |                               | 1 - For<br>State<br>Registrar                                  | State                          | of Ma                |   | partment of I<br>ertificate of                              |   |  | jiene<br>ag. No.         | 15 L                          | 1889   |
|-------------------|--|-------------------------------|--|--------------------------------|----------------------|---|---|---|--|--------------------------|-------------------------------|--|
|                   |  |                               | Decedent's Name (First, Midd                                   | le, Last)                      |                      |   |   |   | 2. Date of Dea                             | th                       |                               | 3. Time of Death                               |
| н                 | Physici<br>/Medic  |                               | George T.  | Weisbeck                       | er                   |   |   |   | Decembe                                    | r 26.                    | 2005                          | 2:59 a M                                       |
|                   | Examin   |                               | 4a. Facility Name (If not institution                          | n, give street and no          | ımber)               |   | 4b. City, Town,   | or Location of Death                          |  |                          | inty of Death                 | ,=.05  |
|                   |  |                               | Greater Baltim   |                                |                      |   | Towson  | •   |  | Ва                       | altimo                        | re   |
|                   | Funeral  |                               | 5. Social Security Number 219-03-6556                          | 6. Sex<br>1√2 M 2 □ F          | _                    | (In yrs. last birthd<br>Yrs               | Months Days   |   | 8. Date of Birth<br>(Month, Day<br>Feb. 11 |                          | 9. Birth                      | place (State or Foreign ntry)                  |
|                   | Director   |                               | Usual Residence of Decedent                                    | X                              | 87                   | 115                                       |   |   | Feb. 11                                    | ,1918                    | Mary                          | land   |
|                   | yland  |                               | 10a. State 10b. County   |                                |                      | 10c. City, Town or                        | Location  |   |  |                          |                               | 10d. Inside City Limits                        |
|                   | a-1 st   | ctor                          | Maryland Balti   | more                           |                      | Towson                                    |   |   |  |                          |                               | 1 ☐ Yes 2 ☐ No                                 |
|                   | or 28  | Jire                          | 10e. Street and Number   |                                |                      |   | 10f. Zip Code   |   | 1  | 0g. Citizen              | of What Cou                   | ntry?  |
|                   | ath w  | rai                           | 8305 Thornton  | Road                           |                      |   | 2120  | J4  |  | USA                      |                               |  |
|                   | er de  | nne                           | 11. Marital Status   | 12. Was Dec<br>Armed F         | orces?               |   | <ol><li>Was Decedent of I<br/>If Yes, specify Cub</li></ol> | Hispanic Origin? (Sp<br>an, Mexican, Puerto   | ecify Yes or No-<br>Rican, etc.)           |                          | Race - Ameri<br>Black, White, |  |
| 36                | rs aft   | oy F                          | 1 ☐ Never Married 2 💢 Mar<br>3 ☐ Widowed 4 ☐ Divorced          | If Yas G                       | ve '                 | 0   | 1 ☐ Yes 2 ☐ No  | Specify:                                      |  | Spe                      | city:                         | hite   |
| 9                 | 2 hou  | ted t                         | 15. Deceder  | it's Education                 | ,u(63.               |   | cedent's Usual Occu   |   |  | 16b. Kind o              | f Business/In                 |  |
| 21215-0036        | within 72 hours after death with the Maryland<br>ene,<br>then "natural", or items 23e or 28e-f show<br>the Medical Exemination is traffled at  | Completed by Funeral Director | (Specify only higher<br>Elementary/Secondary (0-12)            | st grade completed,<br>College | 1-4or 5-             | +\  | ive kind of work done  o. DO NOT use retire                 | d)  |  |                          |                               | n Lines  |
| 7                 | ad wit   | Con                           | 10   |                                |                      | Vic                                       | e Presider  | nt of Sale                                    |  |                          |                               | ng Storage                                     |
| nd                | be filled tal Hydron double sven   | Be                            | 17. Father's Name (First, Middle,                              | ,                              |                      |   |   | 18. Mother's Name                             | e (First, Middle, i                        | Maiden Surr              | name)                         |  |
| Maryland          | ould<br>Men<br>narka<br>natic  | ပို                           | John Freder  |                                | sbec                 |   |   | Margar  |  | Lar                      | <del></del>                   |  |
| ă<br>N            | d 2 sh<br>th and<br>7 Is n<br>traun  | V i                           | 19a. Informant's Name/Relations Dorothy Weisbe                 |                                | f-                   |   | ailing Address (Street                                      |   |  | -                        |                               | ,  |
|                   | 1 an<br>Heal<br>tam 2<br>thar  |                               | 20a. Method of Disposition                                     | CVCT \ MI                      | 1 -                  | 20b. Place of Dis                         | 5 Thornton position (Name of                                |   | wson, Ma<br>Date                           |                          | on - City or To               |  |
| OL                | permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If itam 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic svent, the Medical Experiment and the collined at once.   |                               | 1 Burial 2 Cremation 4 Donation 5 Other (5                     |                                | State                | Hillton                                   | rematory or other pla                                       | ៚  <br>Corp. 12/3                             |  |                          |                               | ,  |
| Baltimore,        | ortan  |                               | 21. Signature Funer Livry                                      | -                              | //                   | Птттебр                                   | 22. Name and Addre  |   | כם קטו                                     | Towsor                   | 19.                           |  |
| m                 | Der Der  |                               | las  | 1. 11                          | 1                    |   | Ruck Towso  | n Funeral                                     | Home.                                      | Inc +                    | JSU You                       | rk Road  |
|                   |  |                               | 23a. Part1. Enter the disease of shock, or heart failure. List | complications that             | caused               | the death. Do not                         | enter the mode of dyi                                       | ng, such as cardiac                           | or respiratory arm                         | est,                     | wson, "                       | Approximate<br>Interval Between                |
|                   | Physician  | 17                            | Immediate Cause (Final disease or condition                    | 11/6                           | . 9                  | intriculi                                 |   |   |  |                          |                               | Onset and Death                                |
| B                 | /Medical<br>Examiner   |                               | resulting in death)  | Due to                         |                      | consequence of):                          | 1   | Humi A<br>Diseas                              |  |                          |                               |  |
|                   | LAGITITIE  | L                             | Sequentially list conditions,                                  | b                              |                      | roughly                                   | Breing  | Diseas  | e  |                          |                               |  |
| _                 | ted<br>nsit  | nine                          | cause. Enter Underlying Cause (Disease or injury               | Dua to                         | (or as a             | consequence of).                          |   |   |  |                          |                               |  |
| 7                 | al-trai  | xar                           | that initiated events<br>resulting in death) Last              | c                              | (or as a             | consequence of):                          |   |   |  |                          |                               |  |
| 68760,            | icate be executed<br>physician and<br>s the burial-transit   | dicai Examiner                |  | d                              |                      |   |   |   |  |                          |                               |  |
|                   | ntificat<br>ng phy<br>as th  | d)                            | 15.55141.5   |                                |                      |   |   |   |  |                          |                               |  |
| Box               | eath certifica<br>attending pl   | Physician/M                   | IF FEMALE:<br>23b. Was decedent pregnant                       | 23c. If yes, ou<br>1 ☐ Live    |                      |   | B Ectopic pregnanc  | V   |  |                          | Date of delive                | ,  |
|                   | e dea<br>the at<br>ned fo  | sici                          | in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown              |                                | nant at t            |   | ☐ Other (specify)   | <u></u>                                       |  | 1                        | Month                         | Day Year                                       |
| P.<br>O.          | The law requires that the death certif<br>ste has been signed by the attending<br>page 2 should be detached for use a  | Phy                           | Part II. Other significant conditi                             | ans contributing to a          | eath bu              | t not resulting in the                    | underhing squae gu  | roo in Bort I                                 | 230 Did tob                                | 2000 1100 01             | noteibuto la th               | ne cause of death?                             |
| Records,          | signe<br>d be o  | 1 by                          | Tall II. Ottor significant conditi                             | one contributing to c          | eath Du              | t not resulting in the                    | didenying cause giv   | on in Fait i.                                 |  | s 2 PNo                  |                               | ably 4 □Unknown                                |
| Sor               | w require<br>been sig<br>should b  | Completed                     |  |                                |                      |   |   |   |  |                          |                               |  |
| Re                | The law<br>cate has<br>page 2  | щć                            |  |                                |                      |   |   |   | 24a. Was a<br>autops<br>perform            | y<br>ned?                | prior to cor<br>death?        | psy findings available<br>mpletion of cause of |
|                   | ician: Th<br>certificate<br>ector, pag   | O                             | 25. Was case referred to medica                                |                                |                      |   |   | 26. Place of Death                            | 1 Yes 2                                    |                          | 1 🗆 Yes                       | 2□No   |
| <u> </u>          | y s  | 0 8                           | examiner?<br>1 ☐ Yes 2 ☑ 🚜 o                                   | Linopital                      | Inpatier             | nt 2 ER/Outpat                            | ent 3 DOA Ott   | ler: 4 🗆 Nursing Ho                           |  |                          | other (Specifi                | ()   |
| 0                 | ding Phys<br>h.<br>After this<br>funeral di  | T inc                         | 27. Manner of Death  1 Natural 5 Pendin                        | 28a. Date                      | of Injury            | Year) 28b. Time                           | of 28c. Injui   | y at  | 28d. Describe ho                           |                          |                               | ,  |
| SIO               | eath.<br>or: Al  | catic                         | 2 Accident investi   | gation                         |                      |   |   | Yes 2 □ No                                    |  |                          |                               |  |
| Division of Vital | or Attandition of Att | Certification:                | 3 Suicide 6 Could 4 Homicide determ                            | ined 286. Place                | of Inju<br>ing, etc. | ry - At home, farm,<br>. <i>(Specify)</i> | street, factory, office                                     |   | 28f. Location (St.<br>City or Town         | reet and Nui<br>, State) | mber or Aura                  | I Route Number,                                |
|                   | pital<br>ours a<br>aral C  |                               | 29a. Certifier 1 Certifyin                                     | o Physician To the             |                      | S Lenguidades de                          | ath and and at the sil                                      | <u> </u>                                      |  |                          |                               | T.   |
|                   | To tha Hospital within 24 hours a To tha Funaral completely filled   | edical                        | (Check only 2 Medical one)                                     | Examinar: On the b             | asis of              | examination and/or                        | ath occurred at the til<br>investigation, in my o           | me, date and place, a<br>pinion, death occurr | and due to the ca<br>ed at the time, da    | iuse(s) and i            | manner as st<br>e, and due to | ated.<br>the cause(s)                          |
|                   | To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funeral Director.   | Me                            | 29b. Signature and title of certifie                           |                                |                      |   | 29c. Licens   | e number                                      | 25   | 9d. Date sign            | ned (Month,                   | Dey, Year)                                     |
|                   | 4  |                               | ) X  |                                |                      | _ ms                                      | 000.  | 57740   | 1  | Decemi                   | bck 2                         | 7, 2005  |
|                   | H  |                               | 30. Name and address of person                                 |                                |                      | - and the second                          |   | n   | 910  |                          |                               |  |
|                   |  |                               | 8501 La Salle  | Rd Ste                         |                      | 2 Tou                                     | SON M   | 0 212   | 24   | ·                        |                               |  |
|                   | Sta<br>Registra  |                               | 31. Date filed (Month, Day, Year)                              | 8 2005                         |                      |   | Coarles   |   |  |                          |                               |  |
|                   |  |                               |  |                                |                      | - 0                                       |   |   |  |                          |                               |  |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

|                     |   |                | For<br>State<br>Registrar  | State of Mar   | -  | artment of F<br>rtificate of                                  |   |  | iene<br>005                                 | 41890  |
|---------------------|---|----------------|--|--|--|---|---|--|---|--|
|                     | Physici<br>/Medic   |                | 1. Decedent's Name (First, Middle, Last  |  | ngling   |   |   | 2. Date of Deat Month Decembe                  | h<br>Day Yea                                |  |
|                     | Examin  |                | 4a. Facility Name (If not institution, give 2917 South   | Snyder   |  | * . A   | r Location of Dea                       |  | 4c. County of De                            |  |
| Ī                   | Funeral<br>Director   |                | 5. Social Security Number 6. Se 214 - 68 - 275 6   | x 7. Age (   | (In yrs. last birthday)<br>4 <sup>9</sup> Yrs. | If Under 1 Year<br>Months Days                                | If Under 24 Hr<br>Hours Mir             |  | Year) 9. B                                  | irthplace (State or Foreign<br>Country)            |
|                     | show  | _              | Usual Residence of Decedent  10a. State 10b. County  |  | Oc. City, Town or Lo                           |   |   |  |   | 10d. Inside City Limits                            |
|                     | ith the Ma<br>or 28a-f  | Director       | Maryland Ballimor  10e. Street and Number  | 1  | Edgeme   | 10f. Zip Code   |   | 10   | og. Citizen of What C                       |  |
|                     | d within 72 hours after death with the Maryland<br>Jiene.<br>r then "neturel", or Items 23e or 28e-f show<br>The Medical Examican result be redified at | Funerai [      | 2513 South Sn.  11. Marital Status   | 12. Was Decedent Ev<br>Armed Forces?                                     | er in U.S. 13.                                 | Vas Decedent of H   |   | Specify Yes or No-<br>rto Rican, etc.)         | 14. Race - Arr<br>Black, Wh                 |  |
| 0036                | hours afte<br>tural', or l  | by             | 1 Never Married 2 Married 3 Widowed 4 Divorced   | 1 ☐ Yes 2 ☑ No<br>If Yes, Give<br>Year or Dates:                         |  | 1□Yes 2M7No   | Specify:                                |  | Specify: W                                  | hite   |
| 1215-               | within 72<br>iene.<br>rthen *nel  | Completed      | 15. Decedent's Edu<br>(Specify only highest grad   | College (1-4or 5+)   | (Give  | tent's Usual Occup<br>kind of work done<br>DO NOT use retired | during most of we                       | orking   | 16b. Kind of Busines $0$ $\mu \eta = t$     | s/Industry<br>Home                                 |
| Maryland 21215-0036 | be filed<br>Ital Hyg<br>Id othe<br>event,   | To Be Co       | 17. Father's Name (First, Middle, Last)  | 1, Ner   |  |   | 1                                       | ame (First, Middle, M                          |   | berger   |
| Mary                | s 1 and 2 should<br>f Health and Men<br>item 27 is marke<br>other treumetic   | Ĕ              | 19a. Informant's Name/Relationship (7) Michael Yingling  | (Spouse)   | 19b. Mailin<br>25 13                           |   | and Number or F                         | Rural Route Number,                            | City or Town, State,                        | 3  |
| Baltimore,          | Pages 1 ar<br>nent of Hea<br>int: If item<br>iry or other   |                | 20a. Method of Disposition  1 □ Burial 2 ☑ Cremation 3 □ F  4 □ Donation 5 □ Other (Specify)   | Removal from State   |  |   |   | Date   | Baltmore                                    | r Town, State                                      |
| Baltii              | pernit. Pages<br>Department of I<br>Importent: If its<br>any njury or o   |                | 21. Sig alure of Funeral Service Licens  | 99   | 22   | Name and Addre  | ss of Facility Vneral Hi                | ome of Dy                                      | ndalk, P.A.                                 |  |
|                     | Pnysician   |                | 23a. Part1. Enter the disease, or compl<br>shock, or heart failure. List only o<br>Immediate Cause (Final                            |  |  | er the mode of dyin   | 1 7 7                                   |  |   | Approximate<br>Interval Between<br>Onset and Death |
|                     | /Medical<br>Examiner  |                | disease or condition resulting in death)   | Due to (or as a c  | consequence of):                               |   |   |  |   | / nm Hg  |
|                     | uted<br>d<br>ansit  | Examiner       | Sequentially list conditions, if any, leading to immediate cause. Lister Unionity and Cause (Disease or injury that initiated events | Due to (or as a d  |  | 31  |   |  |   | ( years  |
| 68760,              | tificate be executed<br>g physician and<br>as the burial-transit  | edicai Exa     | resulting in death) Last   | Due to (or as a o  | consequence of):                               |   |   |  |   |  |
| Box 68              | cer<br>din<br>se  |                | 230. Was decedent pregnant   | 3c. If yes, outcome of 1 ☐ Live birth 2                                  |  | Ectopic pregnancy   |   |  | 23d. Date of de                             | . ,  |
| P.O. B              | D 0 D   | by Physician/M | in the past 12 months?<br>1 ☐ Yes 2 ☐ No<br>9 ☐ Unknown  | 4□Pregnant at tin<br>9□Unknown   | ne of death 5□                                 | Other (specify)   |   |  | Month                                       | Day Year   |
|                     | law requires that the<br>as been signed by th<br>2 should be detache  |                | Part II. Other significant conditions con  | ntributing to death but i  | not resulting in the ur                        | nderlying cause give  | en in Part I.                           | 23e. Did tob                                   | V   | to the cause of death?                             |
| Vital Records,      | The<br>ate h<br>page  | Completed      |  |  |  |   |   | 24a. Was an autopsy perform                    | prior to                                    | utopsy findings available completion of cause of   |
| /ita                | Physicien: Th<br>this certificate<br>ral director, pag  | Be             | 25. Was case referred to medical exeminer?   | 1  |  |   |   | ath (Check only one                            | )   |  |
| of                  | Phys<br>this c  | 2              | 1 Yes 2 No   | lospital: 1   Inpatient  | 2 ER/Outpatient                                |   | 4   Nursing I                           |  | nce 6 Other (Spe                            | ecify)   |
|                     | fing<br>After<br>fune   | tion           | 1 → Natural 5 ☐ Pending<br>2 ☐ Accident investigation  | 28a. Date of Injury<br>(Month, Day Y                                     | (ear) Injury                                   | 28c, Injun<br>Worl  | yat<br><br Yes 2 □ No                   | 28d. Describe how                              | v injury occurred                           |  |
|                     | el or Atter<br>s after dea<br>l Director<br>d in by the   | Certification; | 3 Suicide 6 Could not be<br>4 Homicide determined  | 28e. Place of Injury<br>building, etc. (                                 | - At home, farm, stre<br>Specify)              |   |   | 28f. Location (Str.<br>City or Town,           | eet and Number or R<br>State)               | ural Route Number,                                 |
|                     | To the Hospitel or Attending Ph<br>within 24 hours after death.<br>To the Funerel Director: After th<br>completely filled in by the funeral             | edical         | 29a. Certifier Check only one) Certifying Physical Exami   | sician: To the best of r<br>ner: On the basis of ex<br>and manner stated | amination and/or inv                           | occurred at the tin<br>restigation, in my of                  | ne, date and place<br>pinion, death occ | e, and due to the car<br>urred at the time, da | use(s) and manner a<br>te and place, and du | s stated.<br>e to the cause(s)                     |
|                     | within comp   | Σ              | 29b. Signatura and title of certifier  | 1-11   | hun  | 29c. License  |   |  | d. Date signed (Mon                         | *  |
| •                   | 1   | 9              | Plus Cille   | effect 1   | 110  | 102   | 4356                                    | 0  | elenter F                                   | 1,2005   |
| 1                   | {   |                | 30. Name and address of person who   | incleted cause of death $AFIELO$   | h (Item 23a) (Type, F                          | 910 3 K   | rentelia                                | Sa Mashin                                      | Bult M                                      | 1, 2005<br>Who Green<br>1 21237                    |
|                     | Sta<br>Registr  |                | 31. Date filed (Month, Day, Year)  DFC 2 8 2005  | 32. Registrar's  | Signature                                      | 9   | 2-15-E-E-21                             | 0  | - ' - '                                     |  |

|   | 1 - For<br>State<br>Registrar  |  | Department of Health and<br>Certificate of Death  | Reg. N   | 005 41891  |
|---|--|--|---|--|--|
| Physician<br>/Medical<br>Examiner   | Decedent's Name (First, Middle Charles Stander)     Aa. Facility Name (If not institution)                                 | ley Zabriski   | 4b. City, Town, or Location of Dea  | DECEMBER   | 3. Time of Death 14,2005 5:20P   |
| Funeral<br>Director   | VA MARYLAND F<br>5. Social Security Number<br>089-22-3745  | EALTH CARE SYSTI   |   | 8. Date of Birth   | CECIL  9. Birthplace (State or Foreign New York  |
| after death with the Maryland riteme 23s or 28s-f show other court be notified at Funeral Director              | Usual Residence of Decedent   10a. State   |  | vn or Location  2 de Grace  10f. Zip Code  21078  13. Was Decedent of Hispanic Origin? ( If Yes, specify Cuban, Mexican, Pue                        | us   | 10d. Inside City Limit 1 □ Yes 2 ☒ N itizen of What Country?  A 14. Race - American Indian,        |
| by by   | 3 ☐ Widowed 4 ☐ Divorced   | Year or Dates: 20 year.  | 1 ☐ Yes 2X No Specify:  | 16b.   | Black, White, etc.  Specify: White  Kind of Business/Industry                                      |
| should be filed within 72 hor<br>nd Mental Hygiene.<br>marked other than "neture<br>matic event, II e Mudical E | 17. Father's Name (First, Middle,  | College (1-4or 5+)   | Cook 18. Mother's Na  |  | S. Army<br>In Sumame)  |
| 1 and 2 s<br>Health ar<br>em 27 ls<br>ther treu   | 19a. Informant's Name/Relations  Michael Zabris  20a. Method of Disposition  1 1 Surial 2 Cremation  4 Donation 5 Other (5 | Son 20b. Place of complete   | b. Mailing Address (Street and Number or F<br>Robinhood Rd., Have<br>of Disposition (Name of<br>any, crematory or other place)<br>Wille VA Cem. 12/ | re de Grace<br>Date 20c. l                                       |  |
| bermit. Pages Department of I Importent: If its any injury or o   | Immediate Cause (Final   | complications that caused the death. Do only one cause on each line.   | 22. Name and Address of Facility Mitchell-Smith Fun 1723 S. Washington, not enter the mode of dying, such as cardia                                 | eral Home,<br>Havre de G   | P.A. Tace, MD 21078 Approximate Interval Between Onset and Death                                   |
| Ite be executed and animal-transit he burial-transit he burial-transit here.                                    | cause. Enter Underlying<br>Cause (Disease or injury<br>that initiated events<br>resulting in death) Last                   | a. PROSTATE CA.  Due to (or as a consequence  CARDIOMYOPA'  Due to (or as a consequence  c.  Due to (or as a consequence  d. | r of):<br>THY<br>of):   |  | UNKNOWN  |
| hat the death certifics d by the attending pt letached for use as it Physician/Med                              | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown                                    | 23c. If yes, outcome of pregnancy<br>1 □ Live birth 2 □ Fetal death<br>4 □ Pregnant at time of death<br>9 □ Unknown          | h 3 Ectopic pregnancy 5 Other (specify)   |  | 23d. Date of delivery<br>Month Day Year  |
| igne<br>be d  | Tarrit. Guior significant contain  | ons contributing to death but not resulting  | in the underlying cause given in Part I.  | 23e. Did tobacco<br>1 ☐ Yes 2                                    | use contribute to the cause of death?  2 No 3 Probably Unknow                                      |
|   |  |  |   | 24a. Was an autopsy performer?                                   | 24b. Were autopsy findings availal prior to completion of cause of death?  1  Yes  No              |
| ding Phye   | examiner?<br>1 Tes 2 No  | Hospital: 1 Inpatient 2 EPVO  28a. Date of Injury (Month, Day Year)  28b.  | Other   | eath (Check only one)  Home 5 Thesidence  28d. Describe how inju |  |
| Prite in the  |  | building, etc. (Specify)   |   | City or Town, Stat   |  |
| To the Hospital within 24 hours a To the Funeral I completely filled  | 29a. Certifier (Check only 2 Medical one)  29b. Signature and title of certifier   | Examiner: On the basis of examination a and manner stated.   | pe, death occurred at the time, date and place and/or investigation, in my opinion, death occurred 29c. License number                              | urred at the time, date an                                       | s) and manner as stated.  Individual place, and due to the cause(s)  ate signed (Month, Day, Year) |
| 7 / 8   | > Kanh   | who completed cause of death (Item 23a)  | D40723  |  | EMBER 16, 2005   |
| State<br>Registrar  | KARITHANOM IS 31. Date filed (Month, Day, Year, DEC 2  | SAAC, M. D., VA MAR<br>32 degistrar's Signature  | YLAND HEALTH CARE   | SYSTEM, P  | ERRY POINT, MD   |

|                                |   |  | State of Maryl  |   | artment of I<br><i>tificate of</i>                          |   | Mental Hy                               | rgiene<br>Reg. No.                      | 5 4                                  | 1892  |
|--------------------------------|---|--|---|---|---|---|---|---|--------------------------------------|---|
|                                | Physician   | 1. Decedent's Name (First, Middle, Las   | 1)  |   |   |   | 2. Date of De<br>Month                  | Dey                                     | Year                                 | 3. Time of Death  |
| 1                              | Medical   | 4e Facility Neme (If not institution, give   | estract and number)   |   |   | 4h City Town o                          | 12<br>or Location of Deet               | 7                                       | 05                                   | 5 PM  |
| 1                              | Funeral Director  | HERITAGE I HAR I. 5. Social Security Number 6. Se  | BOJUR HEAL  | 774 + RE<br>yrs. lest birthday)<br>7 Yrs. |   | ANNAP                                   | OCIS                                    | AA oth                                  |                                      | ce (State or Foreign  |
|                                | D   | Usual Residence of Decedent  10a. Stete 10b. County  | 140-  | City, Town or Lo                          |   |   | - 1 - 2                                 | ,                                       |                                      |   |
|                                | Maryla<br>f show  | New Jersey Atlant  |   | Ventnor                                   | cation  |   |   |   | 100.                                 | Inside City Limits 1 ☐ Yes 2 ☑ No                           |
|                                | vith tha Ma   | 10e. Street end Number   |   | VEHEIROI                                  | 10f. Zip Code   |   |   | 10g. Citizen of Wi                      | hat Country                          |   |
|                                | ath will  | 15 South Newark A  | venue   |   | 084   | 406                                     |   | United S                                | States                               | 3   |
| 020                            | within 72 hours aftar death with the Maryland<br>ans.<br>than "natural", or items 23s or 28s-f show<br>its Madical Example, must be notified a<br>propleted by Funeral Director   | 11. Meritel Stetus  1 Never Married 2 Married  3 Widowed 4 Divorced  | 12. Was Decedent Ever in Armed Forces?  1 Yes 2 No If Yes, Give Year or Dates:  |   | Vas Decedent of H<br>Yes, specify Cub<br>☐ Yes 2 No         |   | (Specify Yes or No<br>erto Rican, etc.) | 5- 14. Race<br>Black<br>Specify:        | - American<br>, White, etc.<br>white | ).  |
| Baltimore, Maryland 21215-0020 | permit. Pegas 1 and 2 should be filad within 72 hours aftar death with tha Marylan Department of Haalth and Mantal Hygiana. Important: if Itam 27 is marked other than "natural", or items 23s or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.  To Be Completed by Funeral Director | 15. Decedent's Ed.<br>(Specify only highest grad<br>Elementery/Secondary (0-12)  | cation<br>le completed)<br>College (1-4or 5+)                                   | (Give                                     | ent's Usual Occup<br>kind of work done<br>OO NOT use retire | during most of w                        | rorking                                 | 16b. Kind of Bus                        | iness/Indus                          | itry  |
| /land                          | Mantal Hygi<br>Mantal Hygi<br>Mrked other<br>atic event,<br>To Be Co  | 17. Fether's Neme (First, Middle, Last) Herman Keller  |   |   |   |   | ame (First, Middle<br>(unknow           | , Maiden Sumame<br>n)                   | )                                    |   |
| <b>Jan</b>                     | 2 sho   | 19a. Informant's Name/Relationship (T)   |   |   |   |   |   | er, City or Town, S                     | tate, Zip Co                         | ode)  |
| e,                             | 1 and<br>Haalth<br>Brn 27<br>ther to  | Susan Alten, Daug  |   |   |   |   | exandria<br>Date                        | ,                                       |                                      | State   |
| E O                            | Pegas<br>ent of<br>ry or o  | 1 ☐ Buriel 2 ☐ Cremation 3 ☐ F   | terrioval from State  | b. Place of Dispos<br>cemetery, crem      |   |   |   |   |                                      | Township,   |
| Balti                          | Departm<br>Departm<br>Importa<br>any inju   | 21. Signature of Funeral Service Licens  |   |   | Yachinaky   | s Hebrew                                | Funera1                                 | 5 New Je<br>Home<br>ington, I           |                                      | 0012  |
|                                | Physician<br>/Medical<br>Examiner   | 23a. Part1. Enter the disease, or complished, or heart failure. List only of limited the cause (Final disease or condition resulting in death)             | Cere  | o (or es a consequ                        | Væscu   |   |   | rrest,                                  | Int<br>Or                            | pproximate<br>terval Between<br>nset and Death              |
| 68760,                         | ificeta be axecuted g physician and as tha burial-transit   | Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Lest | o   | o (or es e consequ                        |   |   |   |   |                                      |   |
|                                | = 0.0   |  | 1   |   |   |   |   |   |                                      |   |
| 8                              | death of for us   | Dod II. Other significant annulations  | A-th-sair-sair-sair-t-sair-t-sair-  | M 1- M                                    | 4-11  |   |   |   |                                      |   |
| , P.O.                         | es thet the death cartific<br>igned by the ettending p<br>ba deteched for use as<br>by Physician/Mee  | Part II. Other significant conditions con  | tributing to death but not i  | resulting in the un                       | derlying cause giv  | en in Part I.                           |   |   | ribute to the                        | e cause of death?   |
| Vital Records, P.O. Box        | bean s<br>should  |  |   |   |   |   | 24a. Was<br>perio                       | en eutopsy<br>med?                      | availat                              | autopsy findings<br>ble prior to<br>letion of cause<br>ath? |
| <u>e</u>                       |   | OF Wee man referred to madical   |   |   |   |   | 101                                     |   | 1 □ Y€                               | es 2 No   |
|                                | hysician<br>his cartiti<br>al diractor<br>To Be   | 25. Was case referred to medical examiner?   | lospital: 1  Inpatient 2  | ☐ ER/Outpatient                           | 3□ DOA Oth  |   | eath <i>(Check only c</i>               | <i>ne)</i><br>dence 6 □Other            | (Specify)                            |   |
| Division of                    | ng P  | 27. Manne Death 1 Natural 5 Pending investigation  | 28e. Dete of Injury<br>(Month, Dey Year)  | 28b. Time of                              | 28c. Injur<br>Wor   |   |   | now injury occurred                     |                                      |   |
|                                | To the Hospital or Attanding P within 24 hours after death. To the Funeral Director: After t complately filled in by the funeral Medical Certification:   | 3 ☐ Suicide 6 ☐ Could not be determined  | 28e. Place of Injury - Al<br>building, etc. (Spe                                | ocify)                                    |   |   | City or Tov                             |   |                                      |   |
|                                | the Hospi<br>in 24 hou<br>the Funer<br>plately fil  | one) PLI Medical Examin  | sician: To the best of my k<br>ner: On the basis of exami<br>and manner stated. | nowledge, death<br>ination and/or inve    | occurred at the tin<br>estigation, in my o                  | ne, date and place<br>pinion, death occ | e, and due to the curred at the time,   | cause(s) and manr<br>date and place, an | ner as stated<br>d due to the        | d.<br>e cause(s)  |
|                                | 10<br>2 6 6 6 6 6 6 6 6 6 6 6 6 6 6 6 6 6 6 6   |  | HOPKA   |   | 29c. Licens   | e number                                |   | 29d. Date signed (                      | Month, Day                           | r, Year)  |
|                                |   | 30. Name end eddress of person who co<br>Aditya Chopra, M  | mpleted cause of deeth (It. D., 621 Rid   | tem 23e) (Type, P<br>gely Ave             | rint) #401,   | Annapo.                                 | lis, MD                                 | 21401                                   |                                      |   |
|                                | State<br>Registrar  | 31. Date filed (Month, Day, Year) DEC 1 2 200  | 32 Registrer's Sig  | nature                                    | de la   |   |   |   |                                      |   |

|          |   |                  |  | bets of Mandand (D.   |  |   | •  | 9   |  |
|----------|---|------------------|--|---|--|---|--|---|--|
|          |   |                  | 1 _ State  | tate of Maryland / De   |  |   | ntal Hygien                                      | 9   | 1000                                       |
| _        |   |                  | Registrar  | C   | ertificate of L  |   | Reg. No  | L CUU.                                      | +1893                                      |
| ı        | Physici<br>/Medi  |                  | 1. Decedent's Name (First, Middle, Last) Raymon  | Ernest  | - Ban  | 110   | Dete of Death  Month  De C                       | 1 2005                                      | 3. Time of Death 1745 M                    |
| -        | Examir  |                  | 4a. Facility Name (If not institution, give stree  |   | 4b. City, Town, or   |   | 40   | County of Death                             |  |
|          |   |                  |  | tospital  | Eas  | ton   |  | talbot                                      |  |
|          | Funeral<br>Director   |                  | 5. Social Security Number 6. Sex 112 M Usual Residence of Decedent   | 7. Age (In yrs. last birthde  | Months Dave  | Hours Min.                                      | Date of Birth<br>(Month, Day, Year)<br>VOV. 4 19 | 23 Mar                                      | ace (State or Foreign<br>ry)<br>4/and      |
|          | land  |                  | 10a. State 10b. County   | 10c. City, Town or  | Location   |   |  | 10  | d. Inside City Limits                      |
| )        | 2 hours after death with the Maryland<br>atural; or Itams 23a or 28a-f show<br>sal Examinat must be notified at   | Funeral Director | MD Talbot  | - Ox  | Ford   |   |  |   | 1 No                                       |
| }        | 3a or   | 급                | 10e. Street and Number  206 Market Str   | eet P.O. BOX 17   | 5 216  | 54  | 10g. Cit   | tizen of What Counti                        | ry?  |
|          | death<br>ms 2   | era              | 11. Marital Status 12. V   |   |  |   | v Yes or No-                                     | 14. Race - America                          | n Indian.                                  |
| ٥        | or Ita  | Ē                | 1 Never Married 2 Married 1  | nmed Forces?  ☑Yes 2 □ No  Yes, Give  | 3. Was Decedent of His If Yes, specify Cubar                         |   | can, etc.)                                       | Black, White, et                            | tc.  |
| 5-0036   | ural',  | d by             | 3 ☐ Widowed 4 ☐ Divorced   | ear or Dates:   |  | Specify:  |  | Specify: Bla                                | CK   |
| 7        | within 72 h<br>ane.<br>than "natu   | Completed        | 15. Decedent's Educatio<br>(Specify only highest grade cor   | n 16a. Dec  | cedent's Usual Occupative kind of work done due. DO NOT use retired) | tion<br>uring most of working                   | 16b. K   | ind of Business/Indu                        | ıstry                                      |
| 7        | within<br>ene.<br>than  | dmo              | Elementary/Secondary (0-12)  | ollaga (1-401 5+)   |  | . ,   | 0,   | 1 Comp                                      | 20121/                                     |
| Ö        | Hygi<br>othar<br>ant,   | Be Co            | 17. Father's Name (First, Middle, Last)  | 1 / 4   |  | 18. Mother's Name (F                            |  |   | - Carry                                    |
| <u>a</u> | itd be<br>fental<br>ked<br>ic ev  | To B             | Ernest Bo  | anks  |  | virgir  |  | ar Kley                                     |  |
| ar<br>S  | shou<br>and M<br>s mar<br>umat  |                  | 19a. Informant's Name/Relationship (Type, F  |   | iling Address (Street ar   |   |  |   | Code)                                      |
| , Ma     | and 2   |                  | Evelyn Bar   |   | Market   |   |  | 2.0   | D. 21654                                   |
| o<br>e   | ges 1 and<br>t of Healt<br>If Itam 2<br>or other  |                  | 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Remo   | 20b. Place of Dis   | position (Name of rematory or other place                            | Date  |  | ocation - City or Tow                       |  |
| Ĕ        | nit. Pages<br>artment of l<br>ortant: If It<br>injury or o  |                  | '4 Donation 5 Other (Specify)  | variium State   | n's Cemete   |   | 105 Hu   | rlock N                                     | laryland                                   |
| Sall     | ermit.<br>epart<br>nport<br>ny inj  |                  | 21. Signature of Funeral Service Licensee  | 2/  | 22. Name and Address   | s o Facility He                                 | Me, P. A.  | -   |  |
| _        | 205 9 9   |                  | Janelle Co   | Henry !   | 22. Name and Address<br>Henry Fu<br>5/0 Wash                         | rington S.                                      | t. Cambr   | idge, MD                                    | ,21613                                     |
|          |   |                  | 23a. Part1. Enter the disease, or complication shock, or heart failure. List only one car  | ns that caused the death. Do not e  | inter the mode of dying,   | , such as cardiac or re                         | espiratory arrest,                               | i.  | Approximate<br>nterval Between             |
| · f      | nysician<br>/Modical  | ( 1)             | Immediate Cause (Final disease or condition resulting in death)  | Cardiac O   | Wrest  |   |  |   | Inset and Death                            |
|          | /Medical<br>Examiner  |                  | Toolaning in dealiny   | Due to (or as a consequence of):  | 1  |   |  | C   | _  |
|          |   | ē                | Sequentially list conditions, b.   | Ducto (or as a consequence of).   | rythr  | nia   |  | 0   | 475  |
|          | uted<br>d<br>ansit  | Examiner         | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c. | Command   | arter  | 1. disp   | 600  | 110   | 2003                                       |
| Ś        | be executed<br>ician and<br>burial-transit  | Еха              | resulting in death) Last   | Due to (or as a consequence of):  |  | )   | 1050   |   | 34163                                      |
| -        | e y e   | cal              | d  |   |  |   |  |   |  |
| 0 1      | intifice<br>ing ph  | Med              | IF FEMALE:   |   |  |   |  |   |  |
| ה<br>ה   | ath ce<br>ttendi  | an/I             | 23b. Was decedent pregnant 23c. If   | yes, outcome of pregnancy<br>□Live birth 2 □ Fetal death 3  | Ectopic pregnancy  |   | 2  | 23d. Date of delivery                       |  |
| 5        | Pnystcian: The law requires that the death certifica this certificate has been signed by the attending phral director, page 2 should be detached for use as the   | Physician/Med    | 1 Ves 2 No 4   | ☐Pregnant at time of death 5 ☐ Unknown  | Other (specify)  |   |  | Month D                                     | ay Year                                    |
|          | that the the section of the section |                  | Part III Other significant conditions contribu   | ting to death but not resulting in the  | underlying cause given   | n in Part I                                     | 23e Did tobacco u                                | se contribute to the                        | cause of death?                            |
| 2        | urres<br>sign<br>ld be  | d by             | Hyperlipiden   |   | ,                              |   |  | F   | ly 4 [Unknown                              |
| 3        | s been si<br>should   | lete             | 11   |   |  | -   | 24a. Was an A                                    |   |  |
| ב ב      | cate has t  | Completed        |  |   |  |   | autopsy performed?                               | prior to comp<br>death?                     | y findings available<br>letion of cause of |
| 9        | certificate   | 0                | 25. Was case referred to medical   |   |  | 26. Place of Death (C                           | TLI Yes 2LINo                                    | 1 ☐ Yes 2[                                  | No   |
| >        | rnysician:<br>this certific<br>al director,   | ToB              | examiner?  | al:   | 0#   |   |  | Other (Specify)                             |  |
| ) a      | ff and  |                  | 27. Manner of Death 28   | a. Date of Injury 28b. Time (Month, Day Year)   | of 28c. Injury a Work?   | at 28d.   | Describe how injury                              |   |  |
| 0 1      | leath,<br>tor: A<br>the fu  | cati             | 2 Accident investigation   |   |  | es 2 No   |  |   |  |
|          | or An<br>ifter d<br>Direct<br>in by   | Certification;   | 3 ☐ Suicide 6 ☐ Could not be<br>4 ☐ Homicide determined 28   | <ul> <li>e. Place of Injury - At home, farm, s<br/>building, etc. (Specify)</li> </ul>            | treet, factory, office   | 28f.  | Location (Street and<br>City or Town, State)     | d Number or Rural R                         | loute Number,                              |
| 1        | ours a  |                  | 29a. Certifier 1 Certifying Physicien  | To the best of an incident  |  |   |  |   |  |
|          | loune nospital or Attending within 24 hours after death. To tha Furtheral Director: After completely filled in by the funer   | edical           | Z   Medical Examiner;  | : To the best of my knowledge, dea<br>on the basis of examination and/or in<br>and manner stated. | nvestigation, in my opin   | , date and place, and<br>nion, death occurred a | due to the cause(s)<br>It the time, date and     | and manner as state<br>place, and due to th | ed.<br>e cause(s)                          |
| -        | withir<br>To th<br>comp   | Me               | 29b. algnature and title of certifier  | 100   | 29c. License r   | number  | 29d. Date  | e signed (Month, Da                         | y, Year)                                   |
|          |   |                  | W Miteglo IN   | 1 le lamo (A)   | 10000°   | 9024  | 12   | -112/0                                      | 5-   |
|          |   |                  | 30 Name and address of person who complet  | ed Dayse of death (Item 23a) (Type  | Print)   | 2/2   | e i r  | 1' /  | 7  |
|          |   |                  | Konert M. M.   | Wonald 1  | N.D  | 30 Don  | er St G  | 45tm/                                       | 1) 2/601                                   |
|          | Stat<br>Registra  |                  | 31. Date filed (Month, Day Crear) 1 4 20   | 32. Registrar's Signature   | Broute   |   |  | •   |  |

|                            |  |                                   | For<br>State<br>Registrar  | State of                                | Maryland                                |                      | artment of F                              |  | -                                | giene<br>Reg. No.      | 15 L                           | 1894   |
|----------------------------|--|-----------------------------------|--|---|---|----------------------|---|--|----------------------------------|------------------------|--------------------------------|--|
|                            |  |                                   | Decedent's Name (First, Middle, Last)  |   |   |                      |   | 2. Da                                      |                                  | . Date of Death        |                                | 3. Time of Death                                   |
|                            | Physici<br>/Medio  |                                   | Donald D. B  | rinker                                  |   |                      |   |  | Month<br>12                      | Day<br>1 4             | Year<br>05                     | 11:45P M   |
|                            | Examir   |                                   | 4a. Facility Name (If not institution, give  | street and num                          | ober) Cent                              | er                   | 4b. City, Town, o                         | r Location of Death                        |                                  | 4c. Coun               | ty of Death                    |  |
|                            |  |                                   | Glade Valley N   | ursing                                  |   |                      |   | sville                                     | _                                | Fr                     | ederi                          | ck   |
|                            | Funeral  |                                   | 5. Social Security Number 6. Se  | x<br>3xM 2□F                            | 7. Age <i>(In yr</i> s. <i>Ia</i><br>81 | st birthday)<br>Yrs. | If Under 1 Year<br>Months Days            | If Under 24 Hrs.<br>Hours Min.             | 8. Date of Bir<br>(Month, Da     | y, Year)               | 9. Birthpl<br>Count            | ace (State or Foreign                              |
|                            | Director   |                                   | 164-26-0044   X  | X                                       | 01                                      | TIS.                 |   |  | 3/30/                            | 1924                   | Penn                           | sylvania   |
|                            | land land  |                                   | 10a. State 10b. County   |   | 10c. City,                              | Town or L            | ocation                                   |  |                                  |                        | 10                             | d. Inside City Limits                              |
|                            | Many<br>1-1 sh   | ţō                                | Md Freder  | ick                                     | Fr                                      | ceder                | ick                                       |  |                                  |                        |                                | 1∏Yes 2∏No<br>XX                                   |
|                            | th the<br>or 28s   | ral Director                      | 10e. Street and Number   |   |   |                      | 10f. Zip Code                             |  |                                  | 10g. Citizen o         | f What Count                   |  |
|                            | th wil   |                                   | 188 Fairfield  | Drive                                   | 9                                       |                      |   | 21702                                      |                                  | USA                    |                                |  |
|                            | tems   | Funeral                           | 11. Marital Status   | Armed Fore                              |   | . 13.                | Was Decedent of H<br>If Yes, specify Cuba | lispanic Origin? (Sp<br>an, Mexican, Puert | pecify Yes or No<br>Rican, etc.) | - 14. Ra               | ace - America<br>ack, White, e | an Indian,<br>etc.                                 |
| 36                         | s afte   | by F                              | 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 🛣 Divorced   | 1 ☐ Yes 2<br>If Yes, Give<br>Year or Da | 2 ∏ No<br>• X                           |                      | 1 ☐ Yes 2X No                             | Specify:                                   |                                  | Spec                   | ity: Whi                       | te   |
| 各                          | filed within 72 hours after death with the Maryland<br>Hygiene<br>Hybre rhan "natural", or items 23a or 28a-f show<br>snt, the Macifical Examinar must be notified at  | edt                               | 15. Decedent's Edu   |   | 165.                                    | 16a, Dece            | dent's Usual Occup                        | ation                                      |                                  | 16b. Kind of           | Business/Ind                   | ustry  |
| 715                        | 7 na 7 na 7 na 7 na 7 na 7 na 7 na 7 na  | Completed                         | (Specify only highest grad<br>Elementary/Secondary (0-12)  | e completed) College (1-                | 40r 5+)                                 | (Give                | kind of work done<br>DO NOT use retired   | during most of world)                      | king                             |                        |                                | ,  |
| 21                         | giene<br>grene<br>er the   | E O                               | 12   | College (1                              | 401 547                                 | Mair                 | tenance                                   | Superv                                     | isor                             | Priva                  | te Cl                          | ub   |
| 2                          | be file<br>ital Hy<br>ed oth   | Be (                              | 17. Father's Name (First, Middle, Last)  |   |   |                      |   | 18. Mother's Nam                           | e (First, Middle,                | Maiden Suma            | ime)                           |  |
| <u>S</u>                   | Should Ind Men   | 2                                 | Charles Brin   |   |   |                      |   |  | ra Hut                           |                        |                                |  |
| Maryland 21215-0036        | 12 sh<br>h and<br>7 la m<br>traum  |                                   | 19a. Informant's Name/Relationship (T)   |   |   |                      | ng Address (Street                        |  |                                  |                        | E-2-001 98                     | Accessed to the second                             |
|                            | 1 and<br>Healt<br>em 2<br>ther t   |                                   | Debra A. Brink 20a. Method of Disposition  | er(Dau                                  | ighter<br>20b. Pla                      | 188                  | Fairfi<br>esition (Name of                |  | Frede                            | rick,<br>20c. Location | Md .                           | 21702  |
| ğ                          | permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 Ia marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic avent, the Macheal Examinar must be notified at once. |                                   | MBurial 2 ☐ Cremation 3 ☐ F  | Removal from S                          | tate cer                                | netery, cre          | matory or other place<br>tGrove           | ce)  | 19/05                            |                        |                                |  |
| Baltimore,                 | artme<br>ortani<br>injury  |                                   | <ul><li>4 □ Donation 5 □ Other (Specify)</li><li>21. Signature of Funeral Service Licens</li></ul>   | 88 /                                    | PIE                                     |                      | 2. Name and Addre                         | on of English                              | -                                |                        | nier,                          |  |
| - Ba                       | permit. Departr Importe any inj  |                                   | No 1 1 Af  | 2//                                     | me1035                                  | - 1                  | ell & C                                   | Sy   | nder F<br>t.Ligo                 | unera<br>nier,         | l Hom                          | e<br>5658  |
|                            | Prysician<br>/Medical<br>Examiner  |                                   | 23a. Part1. Enter the disease, or comp<br>shock, or heart failure. List only o   | ications that ca<br>ne cause on ea      | used the death.                         | Do not en            | er the mode of dyin                       | g, such as cardiac                         | or respiratory ar                | rest,                  |                                | Approximate<br>Interval Between<br>Onset and Death |
|                            |  |                                   | immediate daise (rinal disease or condition with the first factor with the factor with the first factor with the first factor with the first factor with the factor with the factor with the first factor with the factor with the factor with the factor with the factor with the factor with the factor with the factor with the factor with the factor with the factor with the factor with the factor wi |   |   |                      |   |  |                                  |                        | Conset and Death               |  |
|                            |  |                                   | resulting in death)  Due to (or as a consequence of):  |   |   |                      |   |  |                                  |                        |                                |  |
|                            |  | <u>~</u>                          | Sequentially list conditions, if any, leading to immediate   | Due to (o                               | or as a conseque                        | ince of):            | aus III                                   | Corde                                      | evanc,                           | sema 100 years         |                                |  |
|                            |  | Examiner                          | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events  | Dan                                     | lete                                    | 5 Mol                | litro                                     | 0  | "N                               | De                     | lens                           |  |
| Ć,                         | be execute<br>sician and<br>burial-trans   | Exa                               | resulting in death) Last   | Due to (o                               | or as a conseque                        | ence of):            | , ,                                       |  | roved                            | liver,                 | NI                             | <b>3</b>   |
| 8760,                      | cate be execut<br>physician and<br>the burial-tran   | dical                             | (  | 1                                       |   |                      |   | A  | 10 WE                            | 100                    |                                |  |
| 9                          |  | To Be Completed by Physician/Medi | IF FEMALE:   |   |   |                      |   | HOP  | 1                                |                        |                                |  |
| Box                        | leath certifi<br>attending p   |                                   | 23b. Was decedent pregnant in the past 12 months?  | 1 🗀 Live bir                            | ome of pregnand<br>th 2 Tetal d         | leath 3[             | Ectopic pregnancy                         | 0  | War C                            |                        | ate of deliver                 | y<br>Day Year                                      |
| 0.6                        | it the dea<br>by the at<br>tached fo   |                                   | 1 □ Yes 2 □ No<br>9 □ Unknown  | 4□Pregna<br>9□Unknov                    | int at time of dea<br>wn                | ith 5                | Other (specify)                           | <i>U</i>                                   |                                  | 141                    | onu (                          | Jay 16ai   |
| P.O.                       | that the   |                                   | Part I Other significant conditions co.  | ntributing to dea                       | ath but not result                      | ing in the u         | nderlying cause givi                      | en in Part I                               | 23e. Did to                      | obacco use cor         | atribute to the                | cause of death?                                    |
| Division of Vital Records, | signe<br>d be  |                                   | Demonto  |   |   |                      | ,   |  | 1 🗆 Y                            | 1/                     |                                | bly 4 □Unknown                                     |
| 202                        | The law requires that the death certifi<br>ate has been signed by the attending<br>page 2 should be detached for use as  |                                   | (P) Lo Fi  | 11105                                   |   |                      |   |  | 24a. Was                         | an 24h                 | Were auton                     | sy findings available                              |
| Re                         | The lav<br>ate has<br>page 2   |                                   | 13 rap 17  | 111                                     |   |                      |   |  | autop                            | sy<br>med2             | prior to com<br>death?         | pletion of cause of                                |
| tal                        | yaician:<br>is certifica<br>director,  |                                   | 25. Was case referred to medical   |   |   |                      |   | 26 Place of Deat                           |                                  | 2 No                   | 1 ☐ Yes 2                      | º∐ No  |
| Ξ                          |  |                                   | examiner?  |   |   |                      |   |  |                                  |                        |                                |  |
| 0                          | ding Ph<br>h.<br>After thi<br>funeral  | :uc                               | 27. Manner of Death 1 □ Natural 5 □ Pending  | 28a. Date of                            | Injury 2<br>, Day Year)                 | 8b. Time o           | 28c. Injun<br>Worl                        |  | 28d. Describe h                  |                        |                                |  |
| Siol                       | uttandii<br>death.<br>ctor: A<br>y the fu  | catlo                             | 2 Accident investigation   | 11 10                                   |   |                      | M 1 🗆                                     |  | Ta                               | 11                     |                                |  |
| ΞŽ                         | or Att   | Certification:                    | 4 Homicide determined 288. Place of injury - At nome, farm building, etc. (Specify)  |   |   |                      | City or Town State)                       |  |                                  |                        |                                |  |
|                            | Hospital 24 hours a Funeral tely filled  |                                   |  |   |   |                      |   |  |                                  |                        | 21793                          |  |
|                            | To the Hospital or Attanowithin 24 hours after death To the Funeral Director: completely filled in by the  | edical                            | (Check only one)   | ner: On the bas                         | sis of examinatio                       | n and/or in          | vestigation, in my of                     | pinion, death occur                        | red at the time, o               | date and place         | , and due to t                 | he cause(s)  |
|                            | To the within 2 To the complete  | Σ                                 | 29b. Signature and title of certifier  |   |   |                      | 29c. License                              | number                                     | :                                | 29d. Date sign         | ed (Month, D                   | ay, Year)  |
| 7                          |  | -                                 | MWS  |   |   | - 1 -                | レ   | CO DO                                      |                                  | 1411                   | 2 00                           |  |
| 41                         | 4-2  |                                   | 34 Nathe and address of person who co  | mpleted cause                           | of death (item 2                        | (Type                | HE FRE                                    | DMO  | 21302                            | )                      | ,                              |  |
|                            | Sta  | te                                | 31. Date filed (Month, Day, Year)  | 32. Re                                  | gistrar's Signatu                       | re                   |   |  |                                  |                        |                                |  |
|                            | Registr  |                                   | DEC 162  | 005                                     | College /                               | M. 14                | perter                                    |  |                                  |                        |                                |  |
| -                          |  | _                                 |  |   |   |                      |   |  |                                  |                        |                                |  |

|                   |  |                  | . For   | State of   |   | d / Depa                      | artment o  | of Health                 | and Me  | ental Hygi   | ene              |                                     | .1005                                      |
|-------------------|--|------------------|---|--|---|-------------------------------|--|---------------------------|---|--|------------------|-------------------------------------|--|
| 200               |  |                  | State<br>Registrar  |  |   | Cei                           | rtificate  | or Deat                   |   |  | U U UoMag        | l.                                  | 1000                                       |
|                   | Physici<br>/Medic  | _                | 1. Decedent's Name (First, Middle, Last)  Paul M. Barth  2. Date of Death Month Day Year December 9, 2005  11:20 P  |  |   |                               |  |                           |   |  |                  | 3. Time of Death  11:20 P M         |  |
|                   | Examin   | _                | 4a. Facility Name (If not institution, give   | e street and num   | ber)  |                               | 4b. City, To   | wn, or Location           | n of Death  |  | 4c. County of    | Death                               |  |
|                   |  | A                | 604 Cannon Road   |  |   |                               | 1  | r Spri                    |   |  | Montg            |                                     |  |
|                   | Funeral<br>Director  |                  | 5. Social Security Number 6. S 222-18-6312  | Sex<br>CXM 2□F   | 7. Age (In yrs.<br>73                                       | last birthday)<br>Yrs.        | If Under 1 Y   | ear If Und                | er 24 Hrs.<br>s Min.  | B. Date of Birth (Month, Day, Dec. 3,  | 1932             | 9. Birthp<br>Cour<br>Ma 1           | place (State or Foreign<br>htry)<br>ryland |
|                   | pu ,   |                  | Usual Residence of Decedent   |  | 100 00  | . Yana ada                    |  |                           |   |  |                  |                                     | IOd Inside City Limite                     |
|                   | within 72 hours after deeth with the Maryland<br>ane.<br>than 'natural', or Itame 23s or 28s-f show<br>he Madical Examiner must be notilled at   | tor              | 10a. State 10b. County  Maryland Montgome   | ery  |   | y,Town or Lo<br>Lver Sj       |  |                           |   |  |                  |                                     | 0d. Inside City Limits 1 ☐ Yes 2 ☐ No      |
|                   |  | Funeral Director | 10e. Street and Number 604 Cannon Road  |  |   |                               | 10f. Zip Code 10g  |                           |   |  | g. Citizen of Wh |                                     | ntry?                                      |
|                   | ne 23  | era              | 11. Marital Status  | 12. Was Dece   | dent Ever in U  | .S. 13.                       |  |                           | Origin? (Spec   | rfy Yes or No-<br>ican, etc.)  |                  |                                     | can Indian,                                |
| 21215-0036        | irs after o  | by Fun           | 1 □ Never Married 2 🗷 Married 3 □ Widowed 4 □ Divorced  | Armed For<br>1 X Yes<br>If Yes, Give<br>Year or Da   | ces?<br>2□No<br>• Kore<br>tesConfl                          | an                            | If Yes, specify 1 ☐ Yes 2 🔀  |                           |   | ican, etc.)  | Specify:         | <sub>White,</sub><br>Whit           |  |
| 9                 | 2 hou  | ed               | 15. Decedent's Ed   | ducation   | COMME   | 16a Dece                      | dent's Usual C   | ccupation                 |   | 1  | 6b. Kind of Busi |                                     |  |
| 715               | nin 72<br>n " ni   | Completed        | (Specify only highest gra<br>Elementary/Secondary (0-12)  | ade completed)  College (1-  | 40r 5+\   | (Give                         | kind of work of<br>DO NDT use i  | done during m<br>retired) | ost of working  | 9  |                  |                                     |  |
| 21,               | d with   | E O              | Liomontary, Socondary (o 12)  | 1  | 40, 51,   | Acc                           | countar  | it                        |   | A  | ccounti          | ng                                  |  |
| land              | ild be file<br>lental Hyg<br>ked othe  | To Be C          | 17. Father's Name (First, Middle, Last, Thomas McQuay   | )  |   |                               |  |                           |   | (First, Middle, M<br>pise Tri  |                  |                                     |  |
| Maryland          | permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Marylar Depertment of Health and Marala Hygiens. Description of Health and Marala Hygiens are returned; or Itama 23a or 28a-f show eny injury of other traumatic event, the Madical Examiner must be notified at once.  |                  | 19a. Informant's Name/Relationship ( June W. Barth/ W   | • •  |   |                               |  |                           |   | Route Number, Spring   | -                |                                     | Code)                                      |
| Baltimore,        |  |                  | 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐   |  | iate  | _                             | osition (Name<br>matory or othe<br>aven Cem  |                           | Decem   | ber 13   | Oc. Location - C |                                     |  |
| altin             | epertme<br>epertme<br>portant<br>v injury  |                  | 4 □Donation 5 □Other (Specification 21. Signature of Funeral Service Licentary)   |  | Gat   | F2                            | 2. Name and A  | Address of Fac            | lins F  | uneral   | Home In          | C                                   | ng, Marylan                                |
| Ш                 | <u>80599</u>   |                  | mohen   | Hol  | e   |                               |  |                           |   |  |                  | ing,                                | , MD 20901                                 |
|                   | F nysecrited / Medical Examiner and prujet it ansit se prujet it ansit | (C. 8            | 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only on a cause on each line.  Immediate Cause (Final disease or condition Hepatrorenal Syndrome 4 Weeks |  |   |                               |  |                           |   |  |                  | Interval Between<br>Onset and Death |  |
|                   |  |                  | resulting in death)   |  | Due to (or as a consequence of):  Cryptogenic Cirrhosis     |                               |  |                           |   |  |                  | ,                                   | Years                                      |
| 760,              |  | Examiner         | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events   | or as a conseq   | s a consequence of):  |                               |  |                           |   |  |                  |                                     |  |
|                   |  | cal Exa          | resulting in death) Last  | Due to (d  | Due to (or as a consequence of):                            |                               |  |                           |   |  |                  |                                     |  |
| 89                | ificati<br>g phy<br>as the   |                  |   | - d.   |   |                               |  |                           |   |  |                  |                                     |  |
| Box               | that the death certificate beed by the ettending physic odetached for use as the b   | Physician/Med    | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  |  |   |                               |  |                           |   | 23d. Date of delivery  Month Day   |                  |                                     |  |
| ls, P.O.          | ires that t<br>signed by<br>d be detac   | by               | Part II. Other significant conditions of  | ath but not res  | not resulting in the underlying cause given in Part I. 23e. |                               |  |                           |   | Did tobacco use contribute to the cause of death?  1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown |                  |                                     |  |
| oro               | To the Hospital or Attending Physicien: The law requires that the death certifical within 24 hours after death. To the Funeral Director: After this certificate has been signed by the ettending phy completely filled in by the funeral director, page 2 should be detached for use as the  | ted              |   |  |   |                               |  |                           |   | : 10   | 24E 110          |                                     | Jabiy 4 Gorikiowii                         |
| Records,          |  | Be Completed     |   |  |   |                               |  |                           |   | 24a. Was an autopsy finding prior to completion of death?  1                               |                  | mpletion of cause of                |  |
| ita               |  |                  | 25. Was case referred to medical examiner?  |  |   |                               |  | 1                         | ace of Death  | (Check only one  | )                |                                     |  |
| <u></u>           | hysic<br>his ce<br>I dire  | 2                | 1 ☐ Yes 2 및 No  | Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Cther: 4 ☐ Nursing Home 5 元Residence 6 ☐ Other (Specify) |   |                               |  |                           |   | 5)   |                  |                                     |  |
| n<br>O            | ng Pl  | ë.               | 27. Manner of Death 1   → Natural 5   → Pending   | 28a. Date o<br>(Monti  | f Injury<br>h, Day Year)                                    | jury 28b. Time o<br>Injury    |  | Injury at Work?           |   | 28d. Describe how injury occurred  |                  |                                     |  |
| sio               | eath.<br>or: A   | cati             | 2 Accident investigatio 3 Suicide 6 Could not b   |  | M 1 Yes 2 N   |                               |  |                           |   |  |                  |                                     |  |
| Division of Vital | el or Atte<br>s after de<br>sl Directo   | Certification:   | 4 Homicide determined   | 4   286, Place of Injury - At nome, farm, street, factory, office   201, Loc                               |   |                               |  |                           | ocation (Street and Number or Rural Route Number,<br>City or Town, State) |  |                  |                                     |  |
|                   | To the Hospitel or Attending within 24 hours after death.  To the Funerel Director: Attencompletely filled in by the fune  | Medical (        | 29a. Certifier 1 S Certifying Pt (Check only one) Medical Example 1   |  | isis of examina   |                               |  |                           |   |  |                  |                                     |  |
|                   |  | Ř                | 29b. Signature and title of certifier   | SD.  | 1   | )                             |  | 20400                     | er .  | 29   | d. Date signed   |                                     |  |
| /                 | 5+1  |                  | 30. Name and address of person who Mark Rosen, MD   | completed cause<br>3941 Fe   | of death (Ite   | /<br>m 23a) (Type,<br>Drive - | Print)   |                           | ng, MD  | 20906  | Decembe          | r 12                                | 2, 2005                                    |
|                   | - Sta  |                  | 31. Date filed (Month, Day, Year)   |  | egistrar's Sign   |                               |  |                           |   |  |                  |                                     |  |
| •7                | Regist   | rar              | DEC 13 20   | JUD COL  | المر ماليا  | 1                             | A CONTRACTOR OF THE PARTY OF TH |                           |   |  |                  |                                     |  |

|                     |  |                | 1 - For State Registrar  | ate of Maryland / De   | partment of Healtl<br>ertificate of Dea                                       | -  | giene 05                            | 41896  |  |  |  |  |  |
|---------------------|--|----------------|--|--|---|--|-------------------------------------|--|--|--|--|--|--|
|                     | Physici<br>/Medi   |                |  |  |   |  |                                     |  |  |  |  |  |  |
|                     | Examir   |                | 4a. Facility Name (If not institution, give street Washington Adventist  | Hospital   | 4b. City, Town, or Location Takoma Par  | on of Death  | 4c. County of Dea                   | uth  |  |  |  |  |  |
|                     | Funeral<br>Director  |                | 5. Social Security Number  190-42-0539  Usual Residence of Decedent  | 7. Age (In yrs. last birthda 38 Yrs.   | Months Dave Hou   |  |                                     | thplace (State or Foreign<br>ountry)<br>nnsylvania |  |  |  |  |  |
| 036                 | Maryland<br>a-f show   | ral Director   | 10a. State 10b. County  Maryland Montgomery  | 10c. City, Town or Silve   | Location<br>r Spring  |  |                                     | 10d. Inside City Limits 1 ☐ Yes 2 ☒ No             |  |  |  |  |  |
|                     | ith with the<br>23a or 28<br>ust be not  |                | 10e. Street and Number 3225 Birchtree Lane   |  | 10f. Zip Code   | 0906   | 10g. Citizen of What C<br>United St |  |  |  |  |  |  |
|                     | permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examples in usite motified at once. | by Fune        | 1 Never Married 2 Married 1  | as Decedent Ever in U.S. 13<br>med Forces?<br>Yes 27 No<br>Yes, Give 13<br>aar or Dates: | 3. Was Decedent of Hispanic<br>If Yes, specify Cuban, Mexi<br>1 Yes 2 No Spec | 14. Race - Am<br>Black, Whi                                | te, etc.                            |  |  |  |  |  |  |
| 21215-0036          | d within 72 h<br>giene.<br>Irr than "natu  | ompleted       | 15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  12  15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired)  None  16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)  None  None   |  |   |  |                                     |  |  |  |  |  |  |
| yland               | ould be file<br>Mental Hy<br>arkad oths<br>atic evant,   | To Be C        | 17. Father's Name (First, Middle, Last) Howard Berman  |  |   | other's Name <i>(First, Middl</i> e<br><b>enita</b> Miller | Maiden Surname)                     |  |  |  |  |  |  |
| Baltimore, Maryland | l and 2 sho<br>lealth and<br>im 27 is m<br>har traum   |                | 19a. Informant's Name/Relationship ( <i>Type, P.</i> Howard Berman, Father   | 3225   | Birchtree La  | ne, Silver S   |                                     | Zip Code)<br>20906                                 |  |  |  |  |  |
| timor               | t. Pages<br>rtment of h<br>rtant: If its<br>njury or ot  |                | 20a. Method of Disposition  1 Burial 2 Cremation 34 Remov  4 Donation 5 Other (Specify)  | Shaare T   | orah Cemetery   |  | 20c. Location - City or Pittsburgh, |  |  |  |  |  |  |
| ■ Bal               | permi<br>Depa<br>Impo<br>any ii  |                | 21. Signature of Funeral Service Licensee  Torchand Address Healington Funeral Home  254 Carroll St., NW, Washington, DC 20012  23a. Particenter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  Approximate  |  |   |  |                                     |  |  |  |  |  |  |
|                     | Physician<br>/Medical  |                | Approximate shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):  |  |   |  |                                     |  |  |  |  |  |  |
|                     | Examiner   | ner            | Sequentially list conditions. b. —   | Oue to (or as a consequence of):   | Personatory failure   |  |                                     |  |  |  |  |  |  |
| 8760,               | tate be executed by sician and the burial-transit  | dical Examiner | Cause (Disease or injury that initiated events c.  | c.  Due to (or as a c requence of):  d. Neuromuscular disorder.                          |   |  |                                     |  |  |  |  |  |  |
| O. Box 68           | the death certific<br>y the attending p<br>ched for use as   | Physiclan/Med  | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ▼ No 9 □ Unknown  | 23d. Date of del<br>Month  | 23d. Date of delivery<br>Month Day Year                                       |  |                                     |  |  |  |  |  |  |
| rds, P              | The law requires that the de<br>tte has been signed by the a<br>page 2 should be detached to   | þ              | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute  1  Yes 2 No 3   |  |   |  |                                     |  |  |  |  |  |  |
| of Vital            |  | Completed      |  | rmed? prior to death?  |   |  |                                     |  |  |  |  |  |  |
|                     | hy<br>this   | ation: To Be   | 27. Manner of Death  1X Natural  2 ☐ Accident investigation  28a   |  |   |  |                                     |  |  |  |  |  |  |
| O N                 | oital or Attandurs after deathural Diractor:   | Certification: | 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural City or Town, State)  |  |   |  |                                     |  |  |  |  |  |  |
|                     | vithin 24 hours at To the Funaral D completely filled is   | Medical        | 29a. Certifier  (Check only one)  Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |  |   |  |                                     |  |  |  |  |  |  |
|                     | 17   |                | 29b. Signature and title of certifier  30. Name and address of correspondence of cor | d cause of death (Item 23a) (Type  | D 63 43   | 39   | 29d. Date signed (Month)            | , Day, Tearj                                       |  |  |  |  |  |
|                     | Stat   | e              | 30. Name and address of person who/complete  NANDURI KUS  31. Date filed (Month, Day, Year)  | WMAKALTA  Registrar's Signature  | (N), 7600 (   | Carrellaver  | nece Mar                            | yland.   |  |  |  |  |  |
|                     | Registra   |                | DEC 13 2005  | 22. Registrar's Signature  | all I   |  |                                     |  |  |  |  |  |  |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. UNK State of Maryland / Department of Health and Mental Hygiene 05-08253 N.IM Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** WARREN LEON BROWN December 0615 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner 4c. County of Death 3000 Steed Road Prince George's Clinton 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) **Funeral**  Birthplace (State or Foreign Country) 1 **3** M 2 □ F Months Days Hours Min. 213-82-2545 Director 33 Aug.6,1972 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location or 28a-f ehow 10d. Inside City Limits the Medical Examiner must be notified at Director MD Prince Georges Clinton 1X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "neturel", or items 23a 11535 Casca Park Place 20735 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. hours after 1 Never Married 2 Married ☐ Yes 2 Yes, Give 2**X** No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐XNo Specify. þ Specify: Black 3 ☐ Widowed 4 ☐ Divorced Year or Dates Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed will Deportment of Heelth and Mental Hygiene Important: if item 27 ie marked other the eny Injury or other treumatic event, the ODES. 12th Coordinator Electronic Corp. 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Sumame) Bryan Williams Betty Brown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Tamela S. Brown- Wife 11535 Cosca Park Pl Clinton, MD 20735 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Elijah Chur. Cem 12/13/05 Poolesville, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SnowdenFuneral Home P.A. 246 N. Washington St Rockville, MD20850 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** multiple Musies /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Box 68760. Be Completed by Physician/Medical use as the attending for use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death Month Day Year 5 Other (specify) Division of Vital Records, P.O. detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Oid tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ✓ Yes 2 □ No 24a. Was an has this certificate 1 Yes 2 □ No after death.

Director: After this certification by the funeral director. 25. Was case referred to medical examiner? 28. Place of Death Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Whether (Specify) Scene ဥ 1XXYes 2 □ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury Month, Day 28d. Describe how jujury occurred. While affixed of motor while Certification: 28b. Time of 28c. Injury at Work? 1 Natural 5 Pending 7-05 2 Accident investigation 1 ☐ Yes 2 No 0602 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28t. Location (Street and Number or Rural Route Number, City or Town State) 4 Homicide filled ree 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medicai (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 29b. Signature and title of certifier 2 29c. License number 29d. Date signed (Month, Day, Year) **OCME** December, 7, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) rol AK MA 111 Penn Street Baltimore, Maryland 21201 ONI 32. Registrar's Signature 31. Date filed (Month, Day, Year) State DEC

Registrar DHMH 17 Rev 1/200

|                                     |  |                 | ricase  | State of Mary  |   |  |  | •                                     | •  | gible.                                  |                                 |                    |
|-------------------------------------|--|-----------------|---|--|---|--|--|---------------------------------------|--|---|---------------------------------|--------------------|
|                                     |  |                 | 1 - State   | State of Mary  |   | rtificate of L                                 |  |                                       | 200  | 15 /                                    | . 120                           | Ω                  |
|                                     |  | -               | Registrar  1. Decedent's Name (First, Middle, Last  | <i>)</i>   | 061                                     | tinicate of L                                  | Jeani                                    | 2. Date of Dea                        | Reg <i>i</i> No.J. (<br>ath  | J U - 1                                 | 3. Time of E                    | Death              |
|                                     | Physici  |                 | CAROLYN F. B  | BUCK   |   |  |  | Decembe                               | er 11.   | 2005                                    | 5:30                            | Рм                 |
|                                     | /Medic<br>े Examir   |                 | 4a. Facility Name (If not institution, give   | street and number)                                     |   | 4b. City, Town, or                             | Location of Death                        | Į.                                    |  | nty of Death                            |                                 |                    |
|                                     |  |                 | 407 Russell Ave.  | Apt#812  |   | Gaither  | sburg                                    |                                       | Mont   | gomer                                   | У                               |                    |
|                                     | Funeral  |                 | 5. Social Security Number 6. Se   | x 7. Age (In<br>☐ M 2X F                               | yrs. last birthday)                     | If Under 1 Year<br>Months Days                 | If Under 24 Hrs.<br>Hours Min.           | 8. Date of Birt<br>(Month, Da)        | h<br>v, Year)  | 9. Birthp                               | lace (State or try)             | Foreign            |
| Ġ.                                  | Director   |                 | 188-36-9896 Usual Residence of Decedent   | 2                | 87 Yrs.                                 |  |  | April 2                               | 2,1918   | Rhode                                   | Islan                           | d                  |
|                                     | land ow  |                 | 10a. State 10b. County  | 100  | City, Town or Lo                        | ocation  |  |                                       |  | 1                                       | 0d. Inside City                 | Limits             |
|                                     | Man<br>a-f eh  | ţō              | Maryland Montgome   | rv   | Gaithe                                  | rshuro   |  |                                       |  |   | 1 🛣 Yes 🥻                       | 2 🗌 No             |
|                                     | th the   | Director        | 10e. Street and Number  |  | ourciic                                 | 10f. Zip Code                                  |  |                                       | 10g. Citizen o   | of What Cour                            | itry?                           |                    |
|                                     | 23a  | Tain            | 407 Russell Avenue  | e, # 812   |   | 20877  | 7  |                                       | U  | SA                                      |                                 |                    |
|                                     | er dez   | Funerai         | 11. Marital Status  | 12. Was Decedent Ever<br>Armed Forces?                 | in U.S. 13.                             | Was Decedent of His<br>f Yes, specify Cubar    | spanic Origin? (Sp<br>n, Mexican, Puerto | ecify Yes or No-<br>Rican, etc.)      | 14. R  | ace - Americ<br>lack, White,            |                                 |                    |
| 36                                  | rs afte  | by F            | 1 ☐ Never Married 2 ☐ Married  3X Widowed 4 ☐ Divorced  | 1 ☐ Yes 2X No<br>If Yes, Give<br>Year or Dates:        |   | 1 ☐ Yes 2X No                                  | Specify:                                 |                                       | Spec   |   |                                 |                    |
| 21215-0036                          | 72 hours after death with the Maryland<br>naturel', or Iteme 23a or 28a-f ehow<br>disal Examinar must be notified at   | ed              | 15. Decedent's Edu  |  | 16a, Dece                               | dent's Usual Occupa                            | ation                                    |                                       | 16b. Kind of   | Whi                                     |                                 |                    |
| 215                                 | hin 7;   | piet            | (Specify only highest grad  | le completed) College (1-4or 5+)                       | (Give                                   | kind of work done d<br>DO NOT use retired)     | luring most of work                      | ing                                   |  | 54011004111                             | 20017                           |                    |
| 21                                  | od wit   | Completed       | Listing (5 12)  | 4  | Но                                      | memaker  |  |                                       | H  | ome                                     |                                 |                    |
| nd                                  | be file<br>d oth   | Be (            | 17. Father's Name (First, Middle, Last)   |  |   |  | 18. Mother's Name                        | e (First, Middle,                     | Maiden Sum   | ame)                                    |                                 |                    |
| <u> </u>                            | ould<br>Men<br>varke   | ို              | Harold  | A. Wilco   |   |  |  | Hazel                                 | М.   |   | ris                             |                    |
| Maryland                            | permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heelth and Mental Hygiene. Important: if item 27 is marked other than "naturel", or items 23a or 28a-f show any injury go other treumatic event, the Medical Examinar must be notified at our |                 | 19a. Informant's Name/Relationship (Ty  | rpe, Print)  |   | ng Address (Street a                           |  |                                       |  |   |                                 |                    |
|                                     | Heelt  |                 | John A. Buck/Son 20a. Method of Disposition   | 21   | 1319<br>Ob. Place of Dispo              | Stateside                                      |  | Silver S                              | opring,<br>20c. Location   |   |                                 |                    |
| nor                                 | ages<br>nut of   |                 | 1 ☐ Burial 2 ☑ Cremation 3 ☐ F<br>4 ☐ Donation 5 ☐ Other (Specify)  | Removal from State                                     | cemetery, cres                          | natory or other place                          | 9)                                       |                                       |  |   |                                 |                    |
| Baltimore,                          | nit. P<br>antme<br>ortan<br>injur  |                 | 21 Sunature of Funeral Service Licens   | 12.4   |   | tan Crema                                      |  |                                       | Alexar   | ndria,                                  | Virgin                          | 11a                |
| B                                   | Dep imp  |                 | The endered   | Melle  | Vec_10                                  | . Name and Addres.<br>East Dee                 | DeVer Park De                            | ol Funer<br>r Gait                    | al Hon   | ne<br>ira M                             | n 2087                          | 77                 |
|                                     | 31   |                 | 23a. Part1. Enter the disease, or compl<br>shock, or heart failure. List only or                            | ications that caused the                               |   |  |  |                                       |  | ilg, ru                                 | Approximate<br>Interval Between |                    |
|                                     | Physician  |                 | Immediate Cause (Final disease or condition   | Cerebral   | Vaccular                                | Accident                                       |  |                                       |  |   | Onset and De                    | eath               |
| 4.                                  | /Medical   |                 | resulting in death)   | Due to (or as a cor                                    |   | Accident                                       |  |                                       |  |   | 4 Days                          | 3                  |
|                                     | Examiner   |                 | Sequentially list conditions.   | b  |   |  |  |                                       |  |   |                                 |                    |
|                                     | pe tis   | Examiner        | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | Due to (or as a cor                                    | nsequence of):                          |  |  |                                       |  |   |                                 |                    |
|                                     | and<br>and<br>Il-tran  | xarr            | that initiated events resulting in death) Last  | c<br>Due to (or as a cor                               | sequence of):                           |  |  |                                       |  |   |                                 |                    |
| 760,                                | icate be executed<br>physicien and<br>s the burial-transit   | cai E           |   |  |   |  |  |                                       |  |   |                                 |                    |
| 687                                 | ificate<br>g phy:<br>as the  |                 | 732   | 1.   |   |  |  |                                       |  |   |                                 |                    |
| ŏ                                   | that the death certifica<br>ed by the attending ph<br>detached for use as th   | Physician/Med   | IF FEMALE: 23b. Was decedent pregnant   | 3c. If yes, outcome of pro                             |   | le . 33. 335.33                                |  |                                       | 23d. E   | Date of delive                          | ry                              |                    |
| m                                   | deat<br>death  | sicia           | in the past 12 months?<br>1 □ Yes 2 🛣 No  | 1 ☐ Live birth 2 ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐   |   | Ectopic pregnancy Other (specify)              |  |                                       | ٨  | Month                                   | Day Ye                          | ar                 |
| <u>Ч</u>                            | at the   | Phy             | 9 Unknown   |  |   |  |  |                                       | The state of the s |   |                                 |                    |
| Division of Vital Records, P.O. Box | The law requires that the death certifica<br>lite hes been signed by the attending ph<br>page 2 should be detached for use as th   | ρ               | Part II. Other significant conditions con   |  |   |  | n in Part I.                             |                                       |  |   | e cause of dea                  |                    |
| 0.0                                 | w requires to been signer should be  | eted            | Atrial Fibrillati   | on, Illeusp  | id kegur                                | gitation                                       |  | 1.6. Y                                | es 2 No  | 3   Prob                                | ably 4 ∐Un                      | known              |
| 3ec                                 | hes b  | Completed       | Dementia  |  |   |  |  | 24a. Was a<br>autops<br>perfor        | SV   | b. Were autop<br>prior to con<br>death? | osy findings av                 | railable<br>use of |
| ø                                   | ician: Th<br>certificate<br>rector, pag  | မ<br>င          | OF Was seen stand to a start  |  |   |  |  | 1 ☐ Yes                               | 2 🖾 No   | 1 Yes                                   | 2□No                            |                    |
| \$                                  | Physician:<br>rthis certifica<br>ral director, p   | 0 B             | 25. Was case referred to medical examiner?  1 ☐ Yes 2 ☒ No  | Hospital:  | 2 ER/Outpatien                          | t 3 DOA Othe                                   | 26. Place of Death                       |                                       |  |   |                                 |                    |
| 1 0                                 | tending Physician: The leath. Ior: After this certificate he the funeral director, page  | $\vdash$ $^{1}$ | 27. Manner of Death   | 28a. Date of Injury<br>(Month, Day Yea                 | 28b. Time of                            | 28c. Injury<br>Work                            | 4 🗆 Ivaising Ho                          | 28d. Describe h                       |  |   | )                               |                    |
| Ö                                   | Attending I<br>or death.<br>ector: After<br>by the funer   | atio            | 1 XNatural 5 ☐ Pending 2 ☐ Accident investigation   | (World, Day 1 ea                                       | lr) Injury                              |  | es 2 □No                                 |                                       |  |   |                                 |                    |
| Σ                                   | or Attendation of the death Director:  | Certification:  | 3 Suicide 6 Could not be<br>4 Homicide determined   | 28e. Place of Injury - A<br>building, etc. (Sp         | At home, farm, stre                     | et, factory, office                            |  | 28f. Location (S.<br>City or Town     | treet and Nun  | nber or Rura                            | Route Numbe                     | <i>∋r</i> ,        |
|                                     | Hospital or<br>24 hours afte<br>Funerel Dir<br>tely filled in I  |                 |   | h .  |   |  |  |                                       |  |   |                                 |                    |
|                                     | Hospital or A<br>24 hours after<br>Funerel Dire<br>etely filled in b   | edical          | 29a. Certifier  (Check only one)  1 ☑ Certifying Physical Examination                                       | sician: To the best of my<br>ner: On the basis of exam | knowledge, death<br>nination and/or inv | occurred at the time<br>restigation, in my opi | e, date and place, inion, death occurr   | and due to the c<br>ed at the time, d | ause(s) and r<br>late and place  | nanner as st                            | ated.<br>the cause(s)           |                    |
|                                     | To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by   | Med             | 29b. Signature and title of certifier   | and manner stated.                                     |   | 29c. License                                   |  |                                       | 9d. Date sign  |   |                                 |                    |
| -                                   | _  |                 | P. Callahary  | tua mo   |   |  | 1794                                     |                                       |  |   | 2, 200                          | 5                  |
| f                                   | 1  |                 | 30. Name and address of person who co   |  | (Item 23a) (Type                        |  |  |                                       |  | 1.00                                    | 7                               | _                  |
|                                     |  |                 | Priscilla Callahan-   | -Lvon M.D.   | 911 Rus                                 | sell Aven                                      | nue, Gait                                | hersbur                               | g, Mar   | yland                                   | 20877                           |                    |
| J.                                  | Sta  | te              | 31. Date filed (Month, Day, Year)   | Registrar's S  | ignature                                | (2)  |  |                                       |  |   |                                 |                    |
|                                     | Registr  | ar              | DEC 13 200  | James 1  | 7                                       | 34   |  |                                       |  |   |                                 |                    |

|                                |  |                  |   | Please  | State of Ma  |               |                              |                          |                     |                                    |                                   |                                       | _         | ible.                   |  |             |
|--------------------------------|--|------------------|---|---|--|---------------|------------------------------|--------------------------|---------------------|------------------------------------|-----------------------------------|---------------------------------------|-----------|-------------------------|--|-------------|
|                                |  | ·                | For<br>State<br>Registrar   |   | Otato of the   |               |                              |                          |                     | Death                              |                                   | Reg. N                                | 711       | 05                      | 418  | 99          |
|                                | Physicia<br>/Medic   |                  | 1. Decedent's Name<br>THO   | MAS HUNT  |  |               |                              |                          |                     |                                    | 2. Date<br>Mor                    |                                       | ay        | Year<br>OS              | 3. Time of 0                                 |             |
|                                | Examin   |                  |   | not institution, giv<br>1 a CUNVIVA                 | e street and number)   | nler          |                              | 4b. City.                | (l                  | r Location of De                   | ath                               | 4                                     |           | ty of Death             | (0   |             |
| ı                              | Funeral<br>Director  |                  | 5. Social Security No. 218-44-62                                    | umber 6. S  |  | e (In yrs. Ia | st birthday)<br>Yrs.         | If Unde<br>Months        | r 1 Year<br>Days    | If Under 24 H<br>Hours M           | in. 8. Date (Mo                   | of Birth<br>orth, Day, Yea<br>27, 194 |           |                         | lace (State or<br>itry)                      | Foreign     |
|                                | aryland<br>show  | 70               | Usual Residence of<br>10a. State<br>MD                              | 10b. County Worces                                  | ter  | 1             | Town or Lo                   |                          |                     |                                    |                                   | -                                     |           | 1                       | 0d. Inside City                              |             |
|                                | with the M<br>or 28a-f   | Funeral Director | 10e. Street and Nun   |   |  |               |                              |                          | Code                |                                    |                                   | 10g. (                                |           | What Cour               | ntry?  |             |
|                                | ne 234   | eral             | 133 W I II  | ter narb  | 12. Was Decedent   | Ever in U.S   | i. 13. V                     |                          |                     | ispanic Origin?<br>an, Mexican, Pu | (Specify Ye                       |                                       | 14. Ra    | ice - Americ            |  |             |
| 036                            | should be filed within 72 hours after death with the Maryland and Mental Hygiene. The Maryland marked other than "natural", or liems 23s or 28s-f show matic event, the Madical Examiner must be notified at | Ď                |   | ed 2⊠ Married<br>4 □ Divorced                       | Armed Forces?  1 X Yes 2 1  If Yes, Give Year or Dates:            | No            |                              | fYes, spe<br>1 ☐ Yes     |                     | Specify:                           | erto Rican, e                     | etc.)                                 |           | ack, White,<br>ify: WHI |  |             |
| 5-0                            | natu   | letec            | (Spec   | 15. Decedent's E<br>ify only highest gr             | ducation<br>ade completed)   |               | 16a. Deced                   | dent's Usu<br>kind of wo | al Occup            | ation<br>during most of v<br>f)    | vorking                           |                                       |           | Business/In<br>g and    | dustry                                       |             |
| 212                            | within<br>jiene.<br>r than "   | Completed        | Elementary/Secon  | ndary (0-12)  | College (1-4or 5<br>5+   | 5+)           | Owner                        |                          | 136 / 6(1160        | "                                  |                                   |                                       |           | nditi                   | oning  |             |
| Baltimore. Marvland 21215-0036 | should be filed and Mental Hygies<br>and Mental Hygies<br>amerked other<br>umatic event, it  | To Be C          | 17. Father's Name (   |   |  |               |                              |                          |                     | 18. Mother's N                     | <sub>lame (First,</sub><br>beth l | Middle, Maide                         |           |                         |  |             |
| <b>Z</b>                       | s 1 end 2 should<br>of Health and Men<br>item 27 is marke<br>other traumatic   |                  | 19a. Informant's Na<br>Diane S.                                     |   |  |               |                              |                          |                     | and Number or<br>rbor Dr           |                                   |                                       |           |                         |  |             |
| ore.                           | iges 1 end 2<br>it of Health<br>it item 27<br>or other tra   |                  | 20a. Method of Disp   |   | Removal from State   | 20b. Pla      | ace of Dispo<br>metery, cren | sition (Na               | me of<br>other plac |                                    | Date                              |                                       |           | - City or To            |  |             |
| ij                             | permit. Pages<br>Depertment of Important: If it,<br>any injury or o  |                  |   | 5 Other (Special                                    | <b>(y</b> )  | Cap           | e Hen                        | lopen                    | Cre                 | m. 12<br>ss of Facility T          |                                   | 005 Fra                               |           |                         |  |             |
| Ba                             | permit. Depertrumports any injury injury.  |                  | Mary  | -MX-V   |  | 00280         |                              |                          |                     | m St.,                             |                                   |                                       |           |                         | лис  |             |
|                                | Physician  |                  |   | ne disease, or com<br>nifailure. List only<br>Final | plications that caused<br>one cause on each lin                    | the death.    |                              |                          |                     | g, such as card                    |                                   | atory arrest,                         |           |                         | Approximate<br>Interval Betw<br>Onset and Do | een<br>eath |
| 4                              | /Medical<br>Examiner   |                  | resulting in death)   | (   | Due to (or as  | a consequ     | ence of):                    | • • •                    | 4 .                 | or veh                             | 1-10                              | - ccid                                | ust.      |                         | 9 Pa   | 43<br>4/    |
|                                |  | Iner             | Sequentially list cor<br>if any, leading to im<br>cause. Enter Unde | nditions,<br>imediate<br>rlying                     | b. Due to (or as   |               |                              | nel v                    | VW F                | or ven                             | icie a                            | 20010                                 |           |                         | , , , ,                                      | 40          |
| -6224<br>760.                  | s be executed<br>sicien and<br>burial-transit  | Examiner         | Cause (Disease or<br>that initiated events<br>resulting in death) L | injury  | cDue to (or as   | a conseque    | ence of):                    |                          |                     |                                    |                                   |                                       |           |                         |  |             |
| -44-                           | licate b<br>physic<br>s the b  | edical           |   |   | d  |               |                              |                          |                     |                                    |                                   |                                       |           |                         |  |             |
| 218-1<br>O. Box                | death cert<br>e attendin   | Physician/Medic  | IF FEMALE: 23b. Was decedent in the past 12 1 □ Yes 2 □ 9 □ Unknown | months?   | 23c. If yes, outcome<br>1 Live birth<br>4 Pregnant at<br>9 Unknown | 2 Fetal       | death 3                      | ]Ectopic p<br>] Other (s |                     |                                    |                                   |                                       |           | ate of delive<br>onth   | ,  | <b>Bar</b>  |
| ess<br>ords. P.                | gned<br>be de  | ۾                | Part II. Other signifi  | icant conditions                                    | contributing to death b  | ut not resul  | lting in the ur              | nderlying                | cause give          | en in Part I.                      | 236                               | e. Did tobacco                        |           |                         | ne cause of de<br>ably 4 🖫ປາ                 | ath?        |
| y less                         | law requir<br>as been si<br>2 should I   | plete            |   |   | Cirosis  |               |                              |                          |                     |                                    | 248                               | . Was an                              | 24b.      | Were auto               | psy findings av                              | vailable    |
| Z W                            |  | Completed        |   |   | Pulm Co  | entas         | cons                         |                          |                     |                                    | 1 -                               | autopsy<br>performed?<br>Yes 2 □      | /         | death?                  | 2□ No  | 126 OI      |
| S Z                            | Physician:<br>this certific<br>ral director,   | To Be            | 25. Was case referrexaminer?  |   | Hospital: 1 Inpatie  | ent 2∏E       | B/Outpatien                  | t 3 🗆 D                  | Oth                 | 26. Ptace of D                     |                                   | conly one)  Residence                 | 6 □Ot     | her /Snecif             | 4)   |             |
| homa                           | ng Phy<br>fter this  |                  | 27. Manner of Death   |   | 28a. Date of Inju<br>(Month, Da)                                   | ry<br>y Year) | 28b. Time of<br>Injury       |                          | 28c. Injun<br>Worl  | y at<br>k?                         | 28d. De                           | scribe how in                         |           |                         | ·/   |             |
| Then                           | Attanding<br>r death.<br>ector: After<br>by the fune   | Certification;   | 2 Accident<br>3 ☐ Suicide   | investigatio  | e 29a Otaco of Ini   |               | ne. farm. str                |                          |                     | Yes 2 YNo                          |                                   | ation (Street                         | and Num   | ber or Rura             | l Route Numb                                 | 197,        |
| D V                            | s efter<br>s efter<br>al Dire<br>ed in b   | Cert             | 4 🗌 Homicide  | determined  | building, etc  | c. (Specify)  |                              |                          | ,,                  |                                    | City                              | Ewbo                                  | ite)      |                         |  |             |
|                                | To the Hospital or Attanding Physician: within 24 hours efter death. To the Funeral Director: After this certific completely filled in by the funeral director.  | Medical          | 29a. Certifier<br>(Check only<br>one)                               |   | nysician: To the best<br>miner: On the basis of<br>and manner sta  | f examination |                              |                          |                     |                                    | ice, and due                      | to the cause                          | (s) and m | anner as s              |  |             |
|                                | To the vithin ?  | Mec              | 29b. Signature and  | title of certifier                                  | and manner ste   | 100.          |                              | 29                       |                     | e number                           |                                   |                                       |           | ed (Month,              | Day, Year)                                   |             |
|                                |  |                  | <b>)</b> (  | mg m  | <i>)</i>   |               |                              |                          | HST                 | 749)                               |                                   | 15                                    | 112       | 105                     |  |             |
| 8                              | T 10+1   |                  | - 1   | ess of person who<br>Snyder,                        | m. D. /p.  | leath (Item:  | 23a) (Type,                  | Print)                   | 4                   | Salishi                            | Lrv r                             | nD a                                  | 1 54      | 0/                      |  |             |
|                                | Sta  |                  | 31. Date filed (Mon   | th_Day, Year)                                       | 2005 32. Pegistra  | ar's Signatu  | ire                          | la M                     |                     | Salisbu                            | 7-1-1                             | , , ,                                 | _, _,     |                         |  |             |
|                                | Registr  | ग                | -   |   | KRRU   | NU !          | ar CA                        | 93                       |                     |                                    |                                   |                                       |           |                         |  |             |

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. U

2005

CHARLES

14. Race - American Indian,

BLACK

RETAIL FOOD SERVICE

NEWTOWN, MARYLAND

23d. Date of delivery

Day

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

Month

20748

Approximate Interval Between Onset and Death

Year

Black, White, etc.

Specify.

16b, Kind of Business/Industry

4c. County of Death

11:12 PM

9. Birthplace (State or Foreign

10d. Inside City Limits

1 Types 2 □ No

WASHINGTON, D.C.

2. Date of Death

DECEMBER 8,

For State Registra

**Physician** 

/Medical

1. Decedent's Name (First, Middle, Last)

EDDIE LOUIS BROWN

Legislation of the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 9 OS D0056949 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6620 Crain Hwy #102 La Plata, Maryland 20646 strar's Signature

Registrar DHMH 17 Rev 1/2001

within 24 hours To the Funeral

Medical

State

29a. Certifier

(Check only one)

29b. Signature and title of certifier

Kamakshi Baig, MD 31. Date filed (Month, Day, Year)

DEC 13

xe.1)

|            |  |               | For<br>State<br>Registrar   | State   | of Marylar  | -                                 | artment<br>rtificate                       |                   |                            | and M            |                                 | giene                    |   | 41901                                 |
|------------|--|---------------|---|---|---|-----------------------------------|--|-------------------|----------------------------|------------------|---------------------------------|--------------------------|---|---------------------------------------|
|            |  |               | 1. Decedent's Name (First, Middle   | e, Last)  |   |                                   |  |                   |                            |                  | 2. Date of De                   | ath                      |   | 3. Time of Death                      |
|            | Physici<br>/Medio  |               | CHARLES LE  | Е воз   | SWELL SE  | ₹.                                |  |                   |                            |                  | Month<br>DECEMB                 | Day<br>ER 7              | Year 2005                                     | 12:58 P M                             |
| }          | Examin   |               | 4a. Facility Name (If not institution   | , give street and n                               | umber)  | -                                 | 4b. City, To                               | own, or           | Location o                 | of Death         |                                 | 4c.                      | County of Deat                                |                                       |
|            |  |               | SOUTHERN MD HO  | SPITAL C  | ENTER   |                                   | CLIN                                       | NOT               |                            |                  |                                 | P                        | RINCE G                                       | EORGE'S                               |
|            | Funeral  |               | 5. Social Security Number   | 6. Sex<br>11∑1M 2□ F                              | 7. Age (In yrs.   |                                   | If Under 1<br>Months                       | Year<br>Days      | If Under 2                 | 24 Hrs.<br>Min.  | 8. Date of Bir<br>(Month, Da    | th<br>y, Year)           | 9. Birth                                      | hplace (State or Foreign untry)       |
|            | Director   |               | 219-58-8223   | IN DOM SCIT                                       | 5   | 3 Yrs.                            |  |                   |                            |                  | FEB.29                          | ,195                     |   | YLÁND                                 |
|            | and *  |               | Usual Residence of Decedent<br>10a. State 10b. County   |   | 10c. Ci   | ty, Town or Lo                    | cation                                     |                   |                            |                  |                                 |                          |   | 10d. Inside City Limits               |
|            | Manyl<br>f sho   | ō             | MD DDTMGE   | CEODGE I  |   |                                   | ١.   |                   |                            |                  |                                 |                          |   | 1 ☐ Yes 2 ☐ No                        |
|            | 28a-   | Directo       | MD PRINCE  10e. Street and Number   | GEORGE 'S   | S CHE   | LTENHA                            | 10f. Zip C                                 | Code              |                            |                  |                                 | 10g. Citi                | zen of What Co                                | untry?                                |
|            | 38 or  |               | 11500 CRAIN HI  | CHWAY   |   |                                   | 206  | 523               |                            |                  |                                 | זו                       | . S. A.                                       | ,                                     |
|            | ours after death with the Marylan<br>ral', or items 23a or 28a-f show<br>Examiner must be notified at  | Funeral       | 11. Marital Status  | 12. Was De  | cedent Ever in U  | J.S. 13.1                         |  |                   | spanic Orig                | gin? (Spe        | ecify Yes or No<br>Rican, etc.) |                          | 14. Race - Amer                               |                                       |
| و          | after<br>or ite  | 큔             | 1 ☐ Never Married 🏖 Marr  | Armed F   | 2-17-No   |                                   |  |                   |                            | , Puerto         | Rican, etc.)                    |                          | Black, White                                  | e, etc.                               |
| 3          | hours a  | l by          | 3 Widowed 4 Divorced  | If Yes, C<br>Year or                              | Dates:  |                                   | 1⊡Yes 2∜                                   | LKNO              | Specify:                   |                  |                                 |                          | Specify: WI                                   | HITE                                  |
| 215-0036   | flied within 72 hours after death with the Maryland<br>Hygiene.<br>other than "naturel", or Items 23a or 28e-f show<br>ant, Ite Medical Examiner must be notified at | Completed     | 15. Deceden<br>(Specify only highes   | s Education                                       | t)  | 16a. Deced                        | tent's Usual<br>kind of work<br>DO NOT use | Occupa<br>done di | tion<br>urina most         | of worki         | na                              | 16b. Ki                  | nd of Business/l                              | Industry                              |
| 2          | han.   | ш             | Elementary/Secondary (0-12)   | T   | (1-4or 5+)  |                                   |  |                   |                            |                  |                                 |                          |   |                                       |
| 7          | filed w<br>Hygie<br>other t  | S             | 10  | (   |   | TRUCK                             | DRIVE                                      |                   | 40.44-0-                   |                  | (F)                             |                          |   | MINISTRATION                          |
| ב          | be fi  | Be            | 17. Father's Name (First, Middle,   |   |   |                                   |  |                   |                            |                  | (First, Middle                  |                          | ,   | 227                                   |
| Ĕ          | should be<br>nd Mental<br>markad<br>maric ev   | <sup>L</sup>  | JOSEPH THOMAS   |   |   | 105 14-10                         |  | C+4-              |                            |                  |                                 |                          | I CHARDS                                      |                                       |
| Maryland 2 | 12<br>ha<br>7 ls   |               | 19a. Informant's Name/Relations   |   |   |                                   |  |                   |                            |                  |                                 |                          | Town, State, Z                                |                                       |
|            | s 1 and<br>f Health<br>itam 27<br>othar tr   |               | JUANITA M. BOS  20a. Method of Disposition  | WELL / WI   |   | 11500<br>Place of Dispo           | CRAIN<br>sition (Name                      | HI(               |                            |                  |                                 |                          | ARYLAND<br>cation - City or 1                 |                                       |
| ٥          | 0  |               | X型Burial 2 ☐ Cremation  |   | n State   | cemetery, crer<br>NITY M          | natory or oth                              | er place          | ' I                        | ECE <sub>2</sub> | - 1                             |                          |   |                                       |
| Baltimore, |  |               | <ul> <li>4 □ Donation 5 □ Other (S)</li> <li>21. Signatore of Funeral Service</li> </ul>  |   | IXI   |                                   |  |                   |                            |                  |                                 |                          | OORF, MA                                      |                                       |
| g          | permit.<br>Depart<br>Import<br>any inj   |               | Loren 12  | ZT Colo   | MOO   | 641 3                             |  | Addiess           | E MAG                      | BRIN             | SFIELD.                         | -ECH(                    | OLS FUNI                                      | L.HME.,P.A.                           |
| ė          |  | -             | 23a. Part1. Enter the disease, or shock, or heart failure. List   | complications that                                | caused the deal   |                                   |  |                   |                            |                  |                                 |                          | re Hall,                                      | MD 20622 Approximate Interval Between |
| ,          | /Medical<br>Examiner   | Examiner      | Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, learning to mine-date cause. Enter Underlying Cause (Disease or injury that initiated events | b. ———  | o (or as a consec   |                                   | Coller                                     | ١ (               | Carc                       | Cimo             | 2                               |                          |   | Onset and Death                       |
| 68/60,     | ificate be executed<br>g physician and<br>as the burial-transit  | dical         | resulting in death) Last  | d.  | o (or as a consec   | quence of):                       |  |                   |                            |                  |                                 |                          |   |                                       |
| .O. Box    | w requires that the death certific<br>been signed by the attending p<br>should be detached for use as:   | hysician/Me   | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown   | 1 Live  | utcome of pregna<br>birth 2 Peta<br>gnant at time of co<br>nown | aldeath 3□                        | Ectopic preg<br>Other (spec                |                   |                            |                  |                                 | 2                        | 3d. Date of deliv<br>Month                    | very<br>Day Year                      |
| S,<br>T    | requires that the<br>een signed by th<br>nould be detache  | by PI         | Part II. Other significant condition  | ns contributing to                                | death but not res   | sulting in the ur                 | nderlying cau                              | ıse giver         | n in Part I.               |                  | 23e. Did to                     | obacco u                 | se contribute to                              | the cause of death?                   |
| cord       | quire<br>in sig<br>uld b   |               | Martensia   | n   |   |                                   |  |                   |                            |                  | 1 🗆 1                           | res 2                    | ]No 3∏Pro                                     | babiy 4 🗆 Unknown                     |
| ဝင္ပ       | law re<br>as bee<br>2 sho  | ompleted      | ' (10   |   |   |                                   |  |                   |                            |                  | 24a. Was                        |                          | 24b. Were aut                                 | opsy findings available               |
| r          | 0 - 2  | E             |   |   |   |                                   |  |                   |                            |                  |                                 | rmed?<br>2 <b>⊠</b> No   | prior to co<br>death?<br>1 \( \sum \text{Yes} | ompletion of cause of                 |
| Vital      | ician: Th<br>certificate<br>rector, pag  | Se C          | 25. Was case referred to medical  |   |   |                                   |  |                   | 26. Place                  | of Death         | 1 ☐ Yes<br>(Check only o        |                          | 10,163  | By No                                 |
| 5          | Phys<br>this<br>aldii  | n; To B       | examiner? 1 ☐ Yes 2 ☒ No  27. Manner of Death   | 28a. Date   | of Injury   | ER/Outpatien<br>28b. Time of      |  | . Injury          | at ING                     |                  | ne 5 Resid                      |                          | Other (Speci                                  | ify)                                  |
| 0          | nding F<br>ath.<br>r: After<br>e funera  | ate           | 1 Natural 5 ☐ Pending<br>2 ☐ Accident investig  |   | nth, Day Year)  | Injury                            | М  | Work?<br>1 □ Y    | ?<br>es 2□N                | 10               |                                 |                          |   |                                       |
| DIVISION   | spital or Attan<br>ours after deat<br>saral Director:<br>filled in by the  | ertification; | 3 ☐ Suicide 6 ☐ Could r<br>4 ☐ Homicide determi   | 289. Plac   | ce of Injury - At hidding, etc. (Specif                         | ome, farm, stre                   | et, factory, o                             | office            |                            | 2                | 8f. Location (5<br>City or Tox  | Street and<br>vn, State) | l Number or Rur                               | ral Route Number,                     |
|            | To the Hospitel or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer   | edical C      | 29a. Certifier (Check only one)  Certifyin 2 Medical I  | g Physician: To the<br>Examiner: On the<br>and ma | ne best of my kno<br>basis of examina<br>nner stated.           | owledge, death<br>tion and/or inv | occurred at<br>estigation, in              | the time          | e, date and<br>nion, deatl | place, a         | nd due to the                   | cause(s)<br>date and     | and manner as s<br>place, and due t           | stated.<br>to the cause(s)            |
| 1          | To th<br>withir<br>To th<br>comp   | Me            | 29b. Signature and title of certifier   | (1) M   | n   |                                   | 29c. l                                     | License           | number                     | ′                |                                 | 29d. Date                | signed (Month,                                | Day, Year)                            |
| (          | 0.   |               | 30. Name and address of person  | who completed cau                                 | use of death (Item  | n 23a) (Type,                     | Print)                                     | 1, 60             | G14.                       | 12/              | 1,0h                            | 10                       | (20 /1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1    | 9, 2005<br>no mo 20712                |
|            | Sta  | te            |   | 32.   | F 1   | 1611 5 · 1                        | 1  | Nt                | 016                        | 106              | WA                              | 510                      | WHILD   | 10 MO 20712                           |
|            | Registr  | ar            | DEC 1   | 3 2005  | THE WAY   | 15. 6                             | Dell                                       | ,                 |                            |                  |                                 |                          |   |                                       |

|                |  |                     | 1 - For<br>State<br>Registrar  | State of Man  |   | artment<br>rtificate                                 |                          |  |   | giene<br>Reg. No. 0 5             | 41902  |
|----------------|--|---------------------|--|---|---|--|--------------------------|--|---|-----------------------------------|--|
|                | Physic<br>/Medi  |                     | Decedent's Name (First, Middle, Last)     Mary Joanne  | Beat  | tie   |  |                          |  | 2. Date of Dea<br>Decembe   | er <sup>Day</sup> 7,20°           | 3. Time of Death 8:25A M                           |
|                | Examir   |                     | 4a. Facility Name (If not institution, give: 7362 Woodhave:  | n Drive   |   | ]  | La I                     | Location of D                              |   |                                   | arles  |
|                | Funeral<br>Director  |                     | 5. Social Security Number  218-30-7911  Usual Residence of Decedent  |   | n yrs. last birthday,<br>71 Yrs.            |  | Days                     | Hours I                                    | Hrs. 8. Date of Birth<br>Min.April 1                              | 8 9 1934                          | Birthplace (State or Foreign<br>Maryland           |
|                | Maryland<br>a-f show   | ctor                | 10a. State 10b. County Charle  |   | Oc. City, Town or Li<br>La Pla              |  |                          |  |   |                                   | 10d. Inside City Limits 1 ☐ Yes 2X No              |
|                | ours after death with the Marylan<br>ral", or Itams 23a or 28a-f show<br>Exertine must be notified at  | Funeral Director    | 10e. Street and Number 7362 Woodhaven  |   |   | 10f. Zip (   | 2                        | 0646                                       |   | 10g. Citizen of Wha               |  |
| 036            | ours after de<br>ral', or itam<br>Exertirer  | by                  | 11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☐ Widowed 4 ☐ Divorced  | 2. Was Decedent Eve<br>Armed Forces?<br>1 Yes 2 No<br>If Yes, Give<br>Year or Dates:                  |   | was Decede If Yes, speci                             |                          | spanic Origin<br>n, Mexican, P<br>Specify: | ? (Specify Yes or No-<br>ruerto Rican, etc.)                      |                                   | American Indian,<br>White, etc.<br>White           |
| 21215-0036     | be filed within 72 hours after death with the Maryland Ital Hyglene. d other than "natural", or itams 23a or 28a-f show event, it w M-dical Exercities must be notified at | Completed           | 15. Decedent's Educify only highest grade  (Specify only highest grade  Elementary/Secondary (0-12)  12  | cation<br>completed)<br>College (1-4or 5+)  | (Give                                       | dent's Usual<br>kind of work<br>DO NOT use<br>DO f R | k done di<br>e retired)  | uring most of                              | working   | 16b. Kind of Busin                | ,  |
| Maryland       | Mental<br>Mental<br>arked o  | To Be               | 17. Father's Name (First, Middle, Last)  Archie Theador  |   |   |  |                          | Cath                                       | Name (First, Middle, erine El                                     | izabeth                           | Ryce 20678   |
|                | es 1 and 2 soft Health ar fitam 27 is rother trau  |                     | 19a. Informant's Name/Relationship (Ty, Peggy Beattie/D) 20a. Method of Disposition 1 ∏Burial 2 □ Cremation 3 □ R  | aughter   | 44<br>20b. Place of Dispo<br>cemetery, cree | L1 So<br>esition (Name<br>matory or oth              | uth<br>e of<br>her place | Shor                                       | Date  | Prince 20c. Location - Cit        | Frederick, MI<br>y or Town, State                  |
| Baltimore,     | permit. Pag<br>Department<br>Important: f<br>any injury o  |                     | 4 □Donation 5 □Other (Specify)  21. Signature of Funeral Service License   | ol) II  | 00945                                       | AREH   | Address<br>ART           | of Facility<br>-ECHO                       | LS FUNER  | AL HOME                           | a,Maryland<br>,P.A.<br>20646                       |
|                | Pnysician<br>/Medical<br>Examiner  |                     | 23a. Part1. Enter the disease, or complishock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)  | eations that caused the e cause on each line.  Due to (or as a co                                     | on C  |  | of dying                 |  | dac or respiratory arr  | est, FID                          | Approximate<br>Interval Between<br>Onset and Death |
| 8760,          | death certificate be executed e attending physician and of for use as the burial-transif   | dical Examiner      | Sequentially list conditions, if any, leading to immediate for the first sequence of the | Due to (or as a co  |   |  |                          |  |   |                                   |  |
| .O. Box 6      | the death certifii<br>y the attending p<br>iched for use as  | Physician/Med       | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  | ic. If yes, outcome of p<br>1 Live birth 2 C<br>4 Pregnant at time<br>9 Unknown                       | Fetal death 3                               | Ectopic pred<br>Other (spec                          |                          |  |   | 23d. Date of<br>Month             | f delivery<br>Day Year                             |
| rds, P         | uires tha<br>signed<br>d be de   | by                  | Part II. Dther significant conditions con  | nbuting to death but no   | ot resulting in the u                       | nderlying cau  | use giver                | n in Part I.                               |   |                                   | te to the cause of death?  Probably 4 ①Unknown     |
| Vital Records, | The law<br>ate has b<br>page 2 sl  | e Completed         | 25. Was case referred to medical   |   |   |  |                          | 00.014                                     |   | y prior<br>ned? deat<br>No 1 🗋    |  |
| of             | ding Phys<br>T.<br>After fhis<br>funeral dir   | Certification: To B | examiner?  | ospital: 1 ☐ Inpatient  28a. Date of Injury (Month, Day Ye)  28e. Place of Injury - building, etc. (S |   | 286<br>M   | c. Injury a Work?        | 4 🗋 Nursin                                 | 28f. Location (St.  | once 6 Other (Sow injury occurred | Specify)<br>or Rural Route Number,                 |
| Q              | To the Hospital or Attentwithin 24 hours after deatl To the Funaral Diractor: completely filled in by the  | edical Cerl         | 29a. Certifying Phys   | cien: To the best of m<br>er: On the basis of exa<br>and manner stated.                               | v knowledge, death                          | occurred at  | t the time               | , date and pl                              | City or Town<br>ace, and due to the ca<br>ccurred at the time, da | use(s) and manne                  | r as stated.<br>due to the cause(s)                |
| )              | To the<br>Within 2<br>To the<br>complet  | Me                  | 29b. Signature and title of certifier  | of Max  | the   | 29c.   | License                  | number                                     | 7   | 9d. Date signed (M                | onth, Day, Year)                                   |
| Jan Jan        | 35   |                     | 30. Name and address of person who cor   | npleted cause of death  | (Item 23a) (Type,                           | ی ا  | fc                       | _ "  | y su  | 064                               | 6  |
|                | Sta<br>Registr   |                     | 31. Date filed (Month, Day, Year) DEC 1 2 20   | 32. Registrar's S   | Signature                                   | book   | •                        |  |   |                                   |  |

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rag. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician John F. Blaser Dec. 2005 4:00p M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Anne Arundel Medical Center Annapolis Anne Arundel 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** 1**⊠**M 2□ F 85 Director 105-12-4494 Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a. State 10d. Inside City Limits crant: if item 27 is marked other than "neturel", or iteme 23a or 28a-f show njury or other traumetic event, tra Madical Examinant matter nothing at MD 1 ☐ Yes 2 ☑ No Anne Arundel Annapolis Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 83 Old Mill Bottom Road 21409 USA death 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: WWII þ 3 Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Engineer Government permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if item 27 is marked other any njury or other traumetic event, 906.8. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Peter Blaser Margaret Soldt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John T. Blaser/Son 1170 Green Holly Court, Annapolis, MD 21409 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State Dec. 13, 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State MD Veterans Cemetery Crownsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 2005 21. Signature of Funeral Service Licensee Barranco & Sons, P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy, Severna Park, MD 21146 pomas EN 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) **Physician** CONGESTIVE HEART LJAG /Medical Due to (or as a consequence of): Examiner SEVERE MUNTIT Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner ng physician and as the burial-transit PANCYTOPENIA MUNTH Due to (or as a consequence of) P.O. Box 68760 LYMPITOMA Physician/Medical ettending IF FEMALE: esn 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, à ANTERY ひに でみっ に COMONIANY 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Inknown Completed FIBRILATION ATRIAL 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an ITY PERTENSION. 1 TYes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certificatompletely filled in by the funeral director; to more death. 25. Was case referred to medical 26. Place of Death (Check only one examiner' Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Impatient 1 ☐ Yes 2 7 No 2 ER/Outpatient 3 DOA 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide 29a, Certifier 1 Scertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29b. Signature and title of certifier WD 00051437 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BITOYE DARLY ANNAPOLIS OKEDWO 31. Date filed (Month, Day, Year)
DEC 1 2 2005 Registrar's Signature Registrar

Bo 05-AK( Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

|   |                            | Registrar   | -41  | Ce                             | rtificate                                   | of Death  | 2. Date of Death                       | g. No.                                | 3. Time of Death   |
|---|----------------------------|---|--|--------------------------------|---|---|--|---------------------------------------|--|
| Physici   | an                         | 1. Decedent's Name (First, Middle, Las  |  | D + 1                          |   |   | Decembe                                | r Day 20                              | Year 12:45 P   |
| /Medic  | al                         |   | Bird   | Butle                          |   | vn, or Location of Dea                                      |  | 4c. County o                          |  |
| Examin  | er                         | 4a. Facility Name (If not institution, give 1119 Cape Anne Wa   |  |                                | Chur  | chton   |  | Anne A                                |  |
| Funeral<br>Director   |                            | 5. Social Security Number 6. S 213-21-4237 1 Usual Residence of Decedent  |  | yrs. last birthday)<br>32 Yrs. | If Under 1 Y<br>Months Da                   | ear If Under 24 Hr.<br>ays Hours Min                        |  | Year)<br>1973 V                       | 9. Birthplace (State or Foreig<br>Country)<br>/irginia                             |
| land<br>ow  |                            | 10a. State 10b. County  | 10c.   | City, Town or Lo               | ocation                                     |   |  | · · · · · · · · · · · · · · · · · · · | 10d. Inside City Limit   |
| Many  | ţ                          | MD Anne Aru   | ındel  | Church                         | ton   |   |  |                                       | 1 □ Yes 2 <b>X∑X</b> V   |
| th the  | lrec                       | 10e. Street and Number  |  |                                | 10f. Zip Co                                 |   | 10                                     | g. Citizen of Wi                      | -  |
| eth w   | - a                        | 1119 Cape Anne Wa   |  |                                |   | 20733   | 0 No No                                | USA                                   |  |
| 72 hours after death with the Maryland<br>"naturel", or lleme 23a or 28e-f ehow<br>dical Examinar must be collified at              | by Funeral Director        | 11. Marital Status  **Never Married 2   Married 3   Widowed 4   Divorced  | 12. Was Decedent Ever i<br>Armed Forces?<br>1 ☐ Yes ② No<br>If Yes, Give<br>Year or Dates: | -                              | Was Decedent<br>If Yes, specify<br>1 Tes XX | of Hispanic Origin? (<br>Cuban, Mexican, Pue<br>No Specify: | Specify Yes or No-<br>rto Rican, etc.) |                                       | - American Indian,<br>, White, etc.<br>White                                       |
| 72 hours<br>"naturel",<br>dical Exe   | To Be Completed            | 15. Decedent's Ec<br>(Specify only highest gra  | l<br>ducation<br>de completed)   | 16a. Dece                      | dent's Usual O                              | ocupation<br>fone during most of we<br>etired)              | orking 1                               | 6b. Kind of Bus                       | iness/Industry   |
| within<br>ene.<br>then "  | mple                       | Elementary/Secondary (0-12)   | College (1-4or 5+)   |                                |   | etired)   |  | ental                                 |  |
| iges 1 and 2 should be filed within 10 fleatin and Mental Hygiene. If Item 27 is marked other then or other treumatic event, the Ma | ပိ                         | 17. Father's Name (First, Middle, Last)   | 4  | Hygen                          | ıst   | 18. Mother's Na   | ame (First, Middle, M                  |                                       | )  |
| ontal h   | Be                         | Richard W. Butler   |  |                                |   |   | ine E. Hai                             |                                       | ,  |
| Shoul<br>nd Me<br>mark  | F                          | 19a. Informant's Name/Relationship (  | ·  | 19b. Maili                     | ng Address (St                              | treet and Number or F                                       |  |                                       | itate, Zip Code)   |
| alth a  |                            | Holly C. Butler-A   | andrews (Sist  | er) 109                        | l Gardn                                     | er Drive,   | Bay Shore                              | , NY 11                               | 706  |
| of Health<br>of Health<br>of Item 27 I  |                            | 20a. Method of Disposition  | 20   | b. Place of Dispo              |   | of  |  |                                       | City or Town, State  |
| Page<br>nent c<br>nnt: If   |                            | 1 ☐ Burial 2 🕅 Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify  | ľ  | letro Cr                       | ematory                                     | 12-1  | 4-2005 B                               | altimor                               | e, MD  |
| permit. Page<br>Department o<br>Important: If<br>eny Injury or  |                            | 21. Signature of Funeral Service Licer  | lg   | 2                              | Hardes                                      | ddress of Facility<br>ty Funeral<br>gely Avenu              | Home, P.                               | Α.                                    | 1757   |
|   |                            | 23a. Part1. Enter the disease, or com<br>shock, or heart failure. List only   | plications that caused the cone cause on each line.  | leath. Do not en               | er the mode of                              | dying, such as cardia                                       | ac or respiratory arre                 | st,                                   | Approximate<br>Interval Between<br>Onset and Death                                 |
| hysician<br>/Medical  |                            | Immediate Cause (Final disease or condition resulting in death)   | a. Excand<br>Due to (or as a con   |                                | tim   |   | •                                      |                                       | Onset and Death  |
| Examiner  | ner                        | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events | b. Ruptu  Due to (or as a con  | sequence of):                  | phag  | ael Vav   | "X                                     |                                       |  |
| eath certificate be executed<br>attending physician and<br>for use as the burial-transit  | Examiner                   | Cause (Disease or injury that initiated events resulting in death) Last   | c. CINNO   | sequence of):                  | + Cu  | uer us  |  |                                       |  |
| fficate be<br>physicia<br>s the bu  | edicai                     | (   | d. Chro  | mic                            | Aco   | urcus   | _                                      |                                       |  |
| 0 0   | Completed by Physician/Med | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  | 23c. If yes, outcome of pre<br>1 Live birth 2 F<br>4 Pregnant at time<br>9 Unknown         | etal death 3                   | ∃Ectopic pregn<br>∃ Other (specif           |   |  | 23d. Date<br>Mont                     | of delivery<br>h Day Year  |
| requires that the<br>een signed by th<br>nould be detache   | d by Ph                    | Part II. Other significant conditions of  | ontributing to death but not   | resulting in the u             | nderlying caus                              | e given in Part I.  | 23e. Did tob                           | 10                                    | oute to the cause of death?  B Probably 4 Unknow                                   |
| e taw<br>hes b  | omplete                    |   |  | -                              |   |   | 24a. Was an autopsy perform            | ed? de                                | ere autopsy findings available for to completion of cause of latin?  Yes 2 \sum No |
| ysician: The is certificate director, pag   | BeC                        | 25. Was case referred to medical examiner?  |  |                                |   |   | eath (Check only one                   | )                                     |  |
| Z 20 €  | 흔                          | 1⊠ Yes 2□ No  |  | 2 ER/Outpatie                  |   |   | Home 5 Resider                         |                                       | GC DCCII   |
| Fing<br>After   | Certification;             | 27. Manner of Death  1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be  |  |                                | М   | Injury at<br>Work?<br>1 Yes 2 No                            | 28d. Describe ho                       |                                       | r or Rural Route Number,   |
| Ital or A   | Certif                     | 4  Homicide determined  | building, etc. (Sp   |                                | eet, factory, or                            | nce   | City or Town,                          |                                       | or result results remove,  |
| To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the t                        | Medical                    |   | ysician: To the best of my<br>niner: On the basis of exam<br>and manner stated.            |                                |   |   |  |                                       |  |
| To the within 2 To the complet  | Σ                          | 29b. Signature and title of certifier   | . /  |                                | 29c. Li                                     | cense number  | 29                                     | d. Date signed                        | (Month, Day, Year)   |
|   |                            | 30, Name and address of person who  | Halla in   | 1.13                           |   | C.M.E.  | 1                                      | December                              | 8, 2005  |
|   |                            | 30. Name and address of person who  | Completed cause of death   |                                |   | reet, Balt  | imore, Ma                              | cyland                                | 21201  |

|       |                     |   |                   | 1 - For<br>State<br>Registrer   | State of Man                                       |                       | artment of F                                     |   |                                 | jiene             | 5 1            | 1905   |
|-------|---------------------|---|-------------------|---|--|-----------------------|--|---|---------------------------------|-------------------|----------------|--|
|       |                     |   |                   | Decedent's Name (First, Middle, Last  | st)  |                       |  | 1   | 2. Date of Dea                  | th                | Vana           | 3. Time of Death                               |
| _     |                     | Physici   |                   | Arthur  | R.   | Bowm                  | aster  | V   | 7 & Com                         |                   | Year<br>Z-V C5 | 11:50# M                                       |
|       |                     | /Medic<br>Examin  |                   | 4a. Fecility Name (If not institution, give   |  | ( )                   | 4b. City, Town, o                                | r Location of Death                             |                                 | 4c. County        | of Death       | Amelel   |
|       |                     |   |                   | Bortimort Washi   | was wro  | him le                | 24-1   | men B.  | wnit                            | nth               | nt '           |  |
|       |                     | Funeral   |                   | Social Security Number     6. Security Number   | 7*V  | n yrs. last birthday) | If Under 1 Year<br>Months Days                   | If Under 24 Hrs. 8<br>Hours Min.                | B. Date of Birth<br>(Month, Day | Year)             | 9. Birthp      | lace (State or Foreign                         |
|       |                     | Director  |                   | 177-12-2230   | 8  | 34 Yrs.               |  |   | April 1                         | 7,1921            | Peni           | nsylvania                                      |
|       |                     | and w   |                   | Usual Residence of Decedent  10a. State 10b. County   | 10   | C. City, Town or L    | ocation  |   |                                 |                   | 1              | 0d. Inside City Limits                         |
|       |                     | death with the Maryland<br>ms 23a or 28a-f show<br>frount be notified at  | Į.                | MD Anne Aru   | ınde1  | Odento                | n  |   |                                 |                   |                | 1 ☐ Yes 21 No                                  |
|       |                     | 28a   | rec               | 10e. Street and Number  | inger  | oucheo                | 10f. Zip Code                                    |   |                                 | 10g. Citizen of V | /hat Coun      | itry?  |
|       |                     | 3a ol   | Funeral Director  | 448 N. Patuxent H   | Road   |                       | 2111   | 13  |                                 | US                | Α              |  |
|       |                     | ms 2  | nera              | 11, Marital Status  | 12. Was Decedent Eve                               | or in U.S. 13.        | Was Decedent of H                                | lispanic Origin? (Spec<br>an, Mexican, Puerto R | ity Yes or No-                  | 14. Race          |                | an Indian,                                     |
|       | 9                   | after<br>or ita   |                   | 1 ☐ Never Married 2 X Married   | 1 XYes 2 □ No                                      |                       | 1 ☐ Yes 2 【XNo                                   |   | ioari, oto.,                    | Specify           |                |  |
|       | 93                  | ours  | d by              | 3 Widowed 4 Divorced  | Year or Dates: V                                   | WII                   |  |   |                                 |                   |                |  |
|       | 5-                  | 72 h<br>"natu   | Completed         | 15. Decedent's Ed<br>(Specify only highest gra  |  | 16a. Dece             | dent's Usual Occup kind of work done             | pation<br>during most of working<br>d)          | g                               | 16b. Kind of Bu   | siness/Ind     | dustry   |
|       | 121                 | within ane.   | dm                | Elementary/Secondary (0-12)   | College (1-4or 5+)                                 |                       | ting Engi  |   |                                 | Excav             | a+i o:         |  |
|       | 2                   | Hygie<br>Hygie<br>thar  |                   | 17. Father's Name (First, Middle, Last)   |  | Opera                 | CING ENGI  | 18. Mother's Name                               | (First, Middle,                 |                   |                | .1   |
|       | Maryland 21215-0036 | d be antal l  | o Be              | John Bowmaster  |  |                       |  | Verna Yea                                       |                                 |                   |                |  |
|       | 2                   | shouth Me Me mark   | 2                 | 19a. Informant's Name/Relationship  | Type, Print)                                       | 19b. Mail             | ng Address (Street                               | and Number or Rural                             |                                 | r, City or Town,  | State, Zip     | Code)  |
|       | <b>S</b>            | od 2 :  |                   | Rose Marie Bowmas   | ster (Wife)  | 448                   | N. Patuxe  | ent Road, C                                     | denton                          | , MD 21           | 113            |  |
|       | <u>ē</u>            | s 1 au<br>f Hea<br>itam<br>othe   |                   | 20a. Method of Disposition  |  | 20b. Place of Disp    | osition (Name of matory or other place           | (ca) Da   | ite                             | 20c. Location -   | City or To     | wn, State                                      |
|       | E                   | Page<br>ient o<br>nt: If  |                   | 1 X Burial 2 ☐ Cremation 3 ☐  `4 ☐ Donation 5 ☐ Other (Specify  | Hemoval from State                                 |                       | Mem. Gdr   | I   | -2005                           | Davids            | onvi]          | lle, MD  |
|       | altimore,           | permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heatih and Mental Hygiene. Important: If item 27 is marked other then "natural", or items 23a or 28a-1 show any injury or other traumatic avant. It a Medical Exertical Exertical be notified at 2000. |                   | 21. Signature of Funeral Service Liger  | IS 66  | 2                     | 2. Name and Addre                                | ess of Facility Funeral H                       | Jome D                          |                   |                | -  |
|       | m                   | e a m a   | (C)               | 175- 9.0  |  |                       |  | ly Avenue                                       |                                 |                   | D 214          | 401  |
|       |                     |   |                   | 23a. Part1. Enter the disease, or com<br>shock, or heart failure. List only                                 | plications that caused the one cause on such line. | e death. Do not en    | ter the mode of dyir                             | ng, such as cardiac or                          | respiratory arr                 | rest,             |                | Approximate<br>Interval Between                |
|       |                     | Priysician  | 10                | Immediate Cause (Final disease or condition   | · Vn   | enm o                 | りつる  |   |                                 |                   |                | Onset and Death                                |
|       |                     | /Medical<br>Examiner  |                   | resulting in death)   | Due to (or as a c                                  | o sequence of):       | - 0  |   |                                 |                   |                |  |
|       |                     | Cxammer   | _                 | Sequentially list conditions,   | b  | > TV V K              |  |   |                                 |                   | _              |  |
| 1     | _                   | sit ed  | Examiner          | Sequentially list conditions, if any, leading to immediate cause. Liner Underlying Cause (Disease or injury | Due to (or as a c                                  | onsequence or):       |  |   |                                 |                   |                |  |
| 5/    |                     | and<br>and<br>I-tran  | хап               | that initiated events<br>resulting in death) Last   | c. Due to (or as a c                               | onsequence of):       |  |   |                                 |                   | -              |  |
| 7     | 8760,               | ate be executed<br>hysician and<br>the burial-transit   | aE                |   |  |                       |  |   |                                 |                   |                |  |
| 4     | 687                 | ate<br>the  | Physician/Medical |   | _ d.   |                       |  |   |                                 |                   |                |  |
| WVZas | Box                 | that the death certificated by the attending placed for use as t  | N/M               | IF FEMALE:<br>23b. Was decedent pregnant  | 23c. If yes, outcome of p                          | pregnancy             | 75 stania managan                                |   |                                 | 23d. Dat          | e of delive    | ery  |
| 13    |                     | death of atten  | icia              | in the past 12 months?<br>1 ☐ Yes 2 ☐ No  | 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at tim             |                       | □Ectopic pregnancy<br>□ Other <i>(specify)</i> _ | у   |                                 | Moi               | nth            | Day Year                                       |
| 3     | P.0                 | the phy the tache   | hys               | 9 🗆 Unknown   | 9□ Unknown   |                       |  |   |                                 |                   |                |  |
| 5     |                     | The law requires that the tite has been signed by the bage 2 should be detache  | by P              | Part II. Other significant conditions of  | ontributing to death but n                         | not resulting in the  | underlying cause gr                              | ven in Part I.                                  | İ                               | . (               |                | ne cause of death?                             |
| 170   | ord                 | w require<br>been sig   | led               |   |  |                       |  |   | 1 🗆 Y                           | es 2 No           | 3 Prob         | ably 4 Unknown                                 |
|       | Vital Records,      | law re<br>as be<br>2 sh   | Completed         |   |  |                       |  |   | 24a. Was a<br>autop             | sv r              | rior to cor    | psy findings available<br>apletion of cause of |
| 5     | H                   |   | Con               |   |  |                       |  |   | perfor                          | med? 25 No 1      | leath?         | 21 No  |
| ۶     | /ita                | cian:<br>ertific<br>ictor,  | Be (              | 25. Was case referred to medical examiner?  |  |                       |  | 26. Place of Death                              | (Check only or                  | ne)               |                |  |
| Ŧ     | of                  | Physi<br>this c   | 은                 | 1 Yes 25 No   | Hospital:  | 2 ER/Outpatie         | 111 3 DOX  | her: 4 Nursing Hom                              |                                 |                   |                | /)   |
| 1     |                     | ding Physician:<br>n.<br>Affer this certific<br>funeral director,   | lon:              | 27. Manner of Death  1  | 28a. Date of Injury<br>(Month, Day Y               | ear) 28b. Time (      | Wo   | ryat<br>rk?<br>]Yes 2 □ No                      | sa. Describe n                  | ow injury occurr  | вα             |  |
| #     | Sic                 | Attandi<br>death.<br>ctor: A<br>y the fu  | icat              | 2 Accident investigation 3 Suicide 6 Could not b  | e One Diese of leiver                              | . At home form o      |  |   | 8f Location (S                  | treet and Numb    | er or Rura     | il Route Number,                               |
|       | Division            | pital or Attano<br>burs after death<br>aral Diractor:<br>filled in by the   | Certification;    | 4  Homicide determined  | building, etc. (                                   | Specify)              | rest, factory, office                            |   | City or Tow                     | n, State)         |                |  |
|       |                     | urs<br>In all   |                   |   | nysicien: To the best of m                         |                       |  |   |                                 |                   |                |  |
|       |                     | To the Hosp<br>within 24 hor<br>To the Fune<br>completely fi  | edicai            | (Check only 2 Medical Exer  | niner: On the basis of ex<br>and manner stated     |                       | nvestigation, in my o                            | opinion, death occurre                          | d at the time, o                | date and place, a | and due to     | the cause(s)                                   |
|       |                     | To tha within 2 To tha complet  | Me                | 29b. Signature and tille of certifier   | )1   | .\                    | 29c. Licens                                      | se number                                       | 2                               | 29d. Date signed  | (Month.        | Day, Year)                                     |
|       |                     |   |                   | 1   | NY.  | D                     | 148  | > 00  | 1.                              | 2/06              | 120            | 05   |
|       | -                   |   |                   |   | completed cause of deat                            | h (Item 23a) (Type    | , Print)   | ) (-)   | 1                               | 32000             | . لـ ه         | mm 7 , n61                                     |
|       |                     |   | -                 | KOFI BUR  |  | > 1 }                 | Losk. 1  | DX- / 2   | 7                               | J V TO V /        | 17/            | 2 400  |
|       | 4                   |   | ate               | 31. Date filed (Month, Day, Year) <b>BEC 1 2 2</b>  | 32 Begistrar's                                     | Signature             | parte  |   |                                 |                   |                |  |
|       |                     | Regist  | rar               | BEOTAL  | 000  |                       |  |   |                                 |                   |                |  |

|   |  |                | 1 - For<br>State<br>Registrar   | State of Marylan  |                   | epartment of Ho<br>Certificate of E                               |  |                                    | iene             | 5 41906  |
|---|--|----------------|---|---|-------------------|---|--|------------------------------------|------------------|--|
|   | Physicia   |                | 1. Decedent's Name (First, Middle, Last)  RUTH EVELYN   | BURNETTE  |                   |   |  | 2. Date of Dear<br>Month<br>DECEMB | h                | 3. Time of Death   |
|   | /Medic<br>Examin   |                | 4a. Facility Name (If not institution, give s   |   |                   | 4b. City, Town, or  | Location of Death  |                                    | 4c. County       |  |
|   |  |                | 37140 TRIPLE CF   | REEK LANE   |                   | MECHANI   | CSVILLE  | 1                                  | ST.              | MARY'S   |
|   | Funeral  |                | 5. Social Security Number 6. Sex  | 7. Age (In yrs.   |                   | Months Days   | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth<br>(Month, Day,   | Year)            | Birthplace (State or Foreign Country)  |
|   | Director   |                | 401-01-1663   | -A. 00  | Yı                | 5.  |  | JAN.14                             | ,1917            | KENTUCKY   |
| land  | WO   |                | 10a. State 10b. County  | 10c. Cit  | y, Town           | or Location   |  |                                    |                  | 10d. Inside City Limits  |
| Man   | beiling  | ctor           | MARYLAND ST. MA   | ARY'S MI  | ECH <i>P</i>      | ANICSVILLE  |  |                                    |                  | 1 ☐ Yes 2 🙀 No   |
| ith the   | or 28  | Director       | 10e. Street and Number  |   |                   | 10f. Zip Code   |  | 1                                  | 0g. Citizen of W | /hat Country?  |
| ath w   | s 23a  | rai            |   | EEK LANE  | 0                 | 2065  |  |                                    |                  | S.A.   |
| ter de  | Hem  | Funeral        | 11. Marital Status  1 ☐ Never Married 2 ☐ Married   | 12. Was Decedent Ever in U.<br>Armed Forces?<br>1 ☐ Yes 2 No  | .S.               | <ol> <li>Was Decedent of His<br/>If Yes, specify Cubar</li> </ol> | spanic Origin? (Spe<br>n, Mexican, Puerto  | ecify Yes or No-<br>Rican, etc.)   |                  | e - American Indian,<br>k, White, etc.   |
| <b>3-0030</b><br>72 hours after death with the Maryland | af, or   | þ              | 3/QWidowed 4 □ Divorced   | If Yes, Give<br>Year or Dates:                                |                   | 1 ☐ Yes ŽÍŽNo   | Specify:   |                                    | Specify.         | WHITE  |
| 72 ho   | natur<br>lical   | Completed      | 15. Decedent's Edu<br>(Specify only highest grade   | cation  | 16a. D            | Decedent's Usual Occupa   | tion   | ina                                | 16b. Kind of Bu  | siness/Industry  |
| ithin   | ne.<br>han "i  | mple           | Elementary/Secondary (0-12)   | College (1-4or 5+)  | 1                 | Give kind of work done di<br>ife. DO NOT use retired)             | aring most of work   | ,,,,                               |                  |  |
| filed within  | Hygiene<br>ither tha   |                | 17. Father's Name (First, Middle, Last)   |   | L_SE              | ECRETARY  | 18. Mother's Name  | /First Middle A                    | HOSPI            |  |
| 9   | ted of   | o Be           |   | IRVINE  |                   |   | GERTRUD  |                                    |                  | <i>5)</i>  |
| ary ia  | and Me<br>is mark<br>sumati  | 10             | 19a. Informant's Name/Relationship (Ty  | · · · · · · · · · · · · · · · · · · ·                         | 19b. N            | Mailing Address (Street a   | The second secon |                                    |                  | State, Zip Code)   |
| 2   | Health a<br>em 27 is<br>sther tra  |                | DIANE KRAMER-DAU  | JGHTER  |                   | OO CARLEY   |  |                                    | •                |  |
|   |  |                | 20a. Method of Disposition 1 ☐ Burial 2X☐Cremation 3 ☐ R  | 20b. P  | lace of Demetery, | Disposition (Name of crematory or other place                     | )  | Date                               | 20c. Location -  | City or Town, State  |
| Pages   | ment<br>tent: i  |                | ' 4 ☐ Donation 5 ☐ Other (Specify)  | METROP  | OLIT              | CIAN CREMA  | TORY 12  | -22-05                             | ALEXA            | NDRIA, VA  |
| Darmit  | Department of Importent: If i any injury or once.  |                | 21. Signature of Funeral Service License  | M00479  | 0                 | 22. Name and Address<br>RAYMOND                                   | s of Facility FUNERAL  | SERVI                              | CE, P.           | Α.   |
|   |  |                | 23a, Part1, Enter the disease, or compli  | cations was used the deat                                     | h. Do ha          | enter he most of vind   | , MARYI<br>, such as car   | AND 29                             | 646              | Approximate  |
| Dh  | weisian  |                | 23a. Part1. Enter the disease, or compli<br>shock, or heart failure. List only or<br>Immediate Cause (Final | e cause of each line.   | 1                 | =                           | F.L  | 2.01                               |                  | Interval Between<br>Onset and Death  |
|   | ysician<br>Medical   |                | disease or condition resulting in death)  | Due to (or as a conse   | u vice of         | gracory   | 1 all  | 2012                               |                  | 475  |
| Ex  | caminer  |                | Sequentially list conditions  |   | tore              | dionly  | opal   | hu                                 |                  | 40   |
| . p   | ÷.   | iner           | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | Due to (or as a consequ                                       | uence of          | 1   | Make   | 1                                  | <b>b</b>         | The state of the s |
| ecute   | and<br>I-trans   | Examiner       | that initiated events resulting in death) Last  | Due to (or as a conseq  | uence of          | mary)   | THUSE  | 411                                | £                | MS   |
| oorou,<br>ificate be executed                           | physician and<br>s the burial-transit  |                |   |   | 40,100 01,        | <i>f</i>  | <i>/</i>   | Y                                  | (                | 1  |
| oo /  |  | edicai         |   | *   |                   |   |  |                                    |                  |  |
| ath cert  | endin<br>use   | M/us           | 23b. was decedent pregnant  | 3c. If yes, outcome of pregna<br>1 ☐ Live birth 2 ☐ Feta      |                   | 3 Ectopic pregnancy   |  |                                    |                  | e of delivery  |
| The law requires that the death cert                    | been signed by the attending<br>should be detached for use a   | Physician/M    | in the past 12 months? 1 □ Yes 2 🖥 No 9 □ Unknown   | 4☐Pregnant at time of di<br>9☐ Unknown                        |                   | 5 Other (specify)   |  |                                    | Mon              | nth Day Year   |
| hat th  | ed by<br>detacl  |                | Part II. Other significant conditions con   | tributing to death but not res                                | ultina in t       | he underlying cause give  | n in Part I.   | 23e. Did tob                       | acco use contri  | ibute to the cause of death?   |
| ulres.  | signe<br>Id be   | d by           | , <   | ALA   |                   | ,   |  |                                    |                  | 3 ☐ Probably 4 🔊 Unknown   |
| ecords,<br>law requires                                 | shou   | lete           | Aa  | Alca. HM  | Du.               | nifm  |  | 24a. Was ar                        | 24b. W           | Vere autopsy findings available  |
| The fa  | e has  | Completed      |   | 200////   | (ZNI)             | VOT IV  |  | autops:<br>perforn                 | y pr<br>ned? di  | rior to completion of cause of eath?  Yes 2 No   |
|   | rtifica<br>stor, p   | BeC            | 25. Was case referred to medical  |   |                   |   | 26. Place of Death   | 1 ☐ Yes 2<br>1 (Check only one     |                  |  |
| OI V  | his ce<br>I direc  | ToE            | 1 103 220140  | lospital: 1   Inpatient 2                                     | ER/Outp           | atient 3 DOA Other  | . 4 Nursing Ho   | me 5 🗗 Reside                      | nce 6 □Othe      | or (Specify)   |
| ding P  | After t  | ion:           | 27. Manner of Death 1   Natural 5 □ Pending   | 28a. Date of Injury<br>(Month, Day Year)                      | 28b. Tin<br>Inje  | ury Work  | ?  | 28d. Describe ho                   | w injury occurre | ed .   |
| ISIC<br>Ittend  | death<br>ctor: /<br>the f  | icat           | 2 Accident investigation 3 Suicide 6 Could not be   | 28e. Place of Injury - At ho                                  | me farm           |   | es 2 No  | 28f Location (St                   | eet and Numbe    | er or Rural Route Number,  |
| DIVISI  | after death.  Director: After this certificate has d in by the funeral director, page 2                                      | Certification; | 4 Homicide determined   | building, etc. (Specify                                       | y)                | i, street, factory, onice   |  | City or Town                       | , State)         | ii Oi naizi noule Nambei,  |
| lospite   | within 24 hours after death.  To the Funeral Director: After this certifica completely filled in by the funeral director, to | edical C       | 29a. Certifier 1 Certifying Phys  | sicien: To the best of my kno<br>ner: On the basis of examina | wledge, o         | death occurred at the time  | e, date and place,   | and due to the ca                  | use(s) and mar   | nner as stated.  |
| the   | hin 24<br>the F  | Medi           | 29b. Signature and title of certifier   | and manner stated.  |                   | 29c. License  |  |                                    |                  | (Month, Day, Year)   |
| To  | T O  |                | 29b. Signature and title or certiner  | I harries   | MI                |   |  |                                    | _                |  |
|   | ()   |                | 30. Name and address of person who co   | mpleted cause of death (Itan                                  | 23a) (To          | ype, Print)   | 0711   |                                    | 1000             | 2-05   |
|   | P  |                |   | ar/boe 24   | 035               | Three Notel   | , Rd H   | olly woo                           | d M.             | 0:20636  |
|   | Sta  |                | 31. Date filed (Month Day, Year)  | 32. Registrar's Signa   | ture              | Secola !  |  |                                    |                  |  |
| *   | Registr  | ar             | DEC 2 8 20  | 305 Services.   | AS.               | The same  |  |                                    |                  |  |

|                            |  |                   |   | State of Ma                                       |                |               |   |                     | Mental Hygi                                   | _             | noie.                    | 100                             | 3 =7      |
|----------------------------|--|-------------------|---|---|----------------|---------------|---|---------------------|---|---------------|--------------------------|---------------------------------|-----------|
|                            |  | 1                 | For<br>State<br>Registrar   |   |                | Cei           | rtificate of  | Death               |   | No.U L        | C                        | +191                            | 11_       |
| П                          | Physicia   | _                 | 1. Decedent's Name (First, Middle,  |   |                |               |   |                     | 2. Date of Death                              | Day           | Year                     | 3. Time of                      |           |
|                            | /Medic   | al .              |   | Barnes  |                |               | 4h Chu Taua   | a Lanation of Dooth | December                                      |               | 2005<br>ty of Death      | 2:45                            | P.M       |
|                            | Examin   | er                | 4a. Facility Name (If not institution, 9<br>1554 Mitchell   | -   |                |               | Aberde  | r Location of Death | 1   |               | larfor                   | d                               |           |
|                            |  |                   |   |   | e (In yrs. las | st birthday)  |   | If Under 24 Hrs.    | 8. Date of Birth                              |               |                          |                                 | r Foreign |
|                            | Funeral<br>Director  |                   | 235-30-8251   | 11X M 2□ F  | 79             | Yrs.          | Months Days   | Hours Min.          | 8. Date of Birth<br>(Month, Day,<br>11/16/19  | 926           | West                     | lace (State o<br>itry)<br>Virgi | nia       |
|                            | pi.  |                   | Usual Residence of Decedent   |   | 100 City       | Town or Lo    | oation  |                     |   |               | 1                        | 0d. Inside Ci                   | tv Limits |
|                            | anyla<br>shov  | 5                 | 10a. State 10b. County  MD Hari   | ford  | 1              | erdeer        |   |                     |   |               |                          | 1 Tyes                          |           |
|                            | the M  | Director          | 10e. Street and Number  | -OLU  | Acc            | Lucci         | 10f. Zip Code   |                     | 10  | g. Citizen of | What Cour                | ntry?                           |           |
|                            | within 72 hours after death with the Maryland<br>jiene.<br>r than "natural", or items 23a or 28a-f show<br>If e Medical Examiner must be notified at   |                   | 1554 Mitchell   | l Lane  |                |               | 21001   |                     |   |               | 5.A.                     |                                 |           |
|                            | death<br>ms 23   | Funerai           | 11. Marital Status  | 12. Was Decedent                                  | Ever in U.S.   | . 13.         | Was Decedent of H<br>If Yes, specify Cuba                     | lispanic Origin? (S | pecify Yes or No-                             |               | ace - Americ             |                                 |           |
| ٥                          | or ite   |                   | 1 ☐ Never Married 2X Marrie   | Armed Forces? d 1 ⊠Yes 2 □ N                      | No             |               | 1 ☐ Yes 2 ☒ No  | Specify:            | o rucan, etc.)                                |               | ack, wille,<br>ity: Whit |                                 |           |
| $\mathbb{R}$               | ural',   | d by              | 3 Widowed 4 Divorced  | If Yes, Give 1 (<br>Year or Dates: -              |                | )             |   |                     | 1.  |               |                          |                                 |           |
| 9500-612                   | - 39   | Completed         | 15. Decedent's<br>(Specify only highest   | Education<br>grade completed)                     |                | (Give         | dent's Usual Occup<br>kind of work done<br>DO NOT use retired | during most of wor  | rking   | 6b. Kind of   | Business/in              | dustry                          |           |
|                            | filed within I Hygiene. other than "rent, the Waren  | шо                | Elementary/Secondary (0-12)   | College (1-4or 5                                  | 5+)            |               | Driver  | •                   | M   | oving         | & Sto                    | rage                            |           |
| D                          | Hygh it  | Be C              | 17. Father's Name (First, Middle, La  | ast)  |                |               |   |                     | ne (First, Middle, M                          |               | ıme)                     |                                 |           |
| Maryland 2                 |  | To E              | Everett Barne   | <b>≥S</b>   |                |               |   | Meliss              | a Mitchel                                     | <u> </u>      |                          |                                 |           |
| a                          | 2 sh<br>and<br>lam<br>aum  | •                 | 19a. Informant's Name/Relationshi   |   | ,              |               |   |                     | ral Route Number,                             |               |                          |                                 |           |
|                            | 1 and 3<br>Health<br>tem 27  |                   | Hazel P. Barr   | nes (Spouse                                       |                |               | 4 Mitchel   | I Ln.               | Aberdeen,                                     | Oc. Location  |                          | 21001                           |           |
| <u>0</u>                   | (h) ()   |                   | 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3   |   | cer            | metery, crer  | matory or other plan  |                     |   |               |                          | arylan                          | 4         |
| Baltimore,                 | permit. Page<br>Department of<br>Important: If<br>any injury of<br>once.   |                   | * 4 □Donation 5 □ Other (Special Service Li   |   | паг            |               |   |                     |   |               |                          | 12 / 2011                       |           |
| g                          | Department of the population o |                   | ) Z   | ). 1000   | -11            |               | Tarring-C<br>Aberdeen.  | argo Fun<br>Marvlan | eral Home<br>d 21001-                         | 3399          | •                        |                                 |           |
|                            |  |                   | 23a. Part1. Enter the disease, or c<br>shock, or heart failure. List or                                     | omplications that caused                          | the death.     | Do not ent    | ter the mode of dyir  | ng, such as cardia  | or respiratory arre                           | st,           |                          | Approximat<br>Interval Bet      | ween      |
| 3                          | Physician  |                   | Immediate Cause (Final disease or condition   |   | nal            | Cer           | 1 Can   | como.               | ma  |               | 6                        | Onset and                       |           |
|                            | /Medical<br>Examiner   |                   | resulting in death)   | Due to (or as                                     | a conseque     | ence of):     |   |                     |   |               |                          |                                 |           |
|                            | Examiner   |                   | Sequentially list conditions,   | b   | 2 000000000    | ance of):     |   |                     |   |               |                          |                                 |           |
| (I                         | ted  | nine              | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | Due to (or as                                     | a conseque     | silve oi).    |   |                     |   |               |                          |                                 |           |
| Ţ                          | te be executed ysician and ne burial-transit   | Examiner          | that initiated events<br>resulting in death) Last   | c<br>Due to (or as                                | a conseque     | ence of):     |   |                     |   |               |                          |                                 |           |
| 1,097                      | te be<br>ysicia<br>ne bur  | cai               |   | d   |                |               |   |                     |   |               |                          |                                 |           |
| B9                         | The law requires that the death certificate ate has been signed by the attending physicage 2 should be detached for use as the   | by Physician/Medi | IF FEMALE:  |   |                |               |   |                     |   |               |                          |                                 |           |
| Box 68                     | ath ce   | ian/              | 23b. Was decedent pregnant in the past 12 months?   | 23c. If yes, outcome                              | 2 Fetal o      | death 3[      | Ectopic pregnanc  | у                   |   |               | ate of delive<br>Month   |                                 | Year      |
| P.O.                       | the a  | ysic              | 1 ☐ Yes 2 ☐ No<br>9 ☐ Unknown   | 4 ☐ Pregnant at<br>9 ☐ Unknown                    | t time or dea  | atn 5L        | Other (specify) _   |                     |   |               |                          |                                 |           |
| <u>.</u>                   | that the ded by detact   | y Ph              | Part II. Other significant condition  | s contributing to death b                         | out not result | ting in the u | inderlying cause giv  | ven in Part I.      | 23e. Did tob                                  | acco use co   | ntribute to t            | ne cause of c                   | leath?    |
| ds                         | quires<br>n sigr   |                   |   |   |                |               |   |                     | 1 🗌 Ye  | 2 No          | 3 🗌 Prot                 | ably 4 🗀                        | Jnknown   |
| 000                        | aw require<br>s been sig<br>2 should t   | Completed         |   |   |                |               |   |                     | 24a. Was an                                   |               | . Were auto              | psy findings                    | available |
| H                          | Physician: The lav<br>this certificate has<br>al director, page 2  | mo;               |   |   |                |               |   |                     | perform                                       | ed?<br>☑ No   | death?                   | 2 □ No                          |           |
| Ita                        | sian:<br>ertifica<br>ctor, I   | Bec               | 25. Was case referred to medical examiner?  |   |                |               |   |                     | ath (Check only one                           | )             |                          |                                 |           |
| <u></u>                    | hyeic<br>this co   | 2                 | 1 ☐ Yes 2 No  | Hospital:   |                | R/Outpatier   | nt 3LI DOA  |                     | forme 5 Resider                               |               |                          | y)                              |           |
| Division of Vital Records, | ding F   | tion              | 27. Manner of Death  1   Natural  5 □ Pending investiga   |   | y Year)        | Injury        | Wo  | rk?<br> Yes 2∐No    | 200. Describe no                              | w mijary occi | 31160                    |                                 |           |
| isi.                       | deatl<br>deatl<br>ctor:<br>y the   | fical             | 3 Suicide 6 Could no  | ot be 28e. Place of Inj                           | jury - At hon  | ne, farm, st  | reet, factory, office   |                     | 28f. Location (Str.                           | eet and Nun   | nber or Rura             | al Route Num                    | ber,      |
|                            | al or /<br>s after<br>il Dire  | Certification:    | 4  Homicide   | building, et                                      | tc. (Specify)  |               |   |                     | City or Town,                                 | State)        |                          |                                 |           |
|                            | To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certifica completely filled in by the funeral director, E  |                   | 29a. Certifier 1 Certifying   | Physician: To the best<br>xaminer: On the basis o | of my know     | rledge, deat  | th occurred at the ti   | me, date and place  | e, and due to the ca<br>urred at the time, da | use(s) and n  | nanner as s              | tated. the cause(s              | 5)        |
|                            | ths hin 24 the F   | Medical           | one)  | and manner st                                     | ated.          |               |   |                     |   |               |                          |                                 |           |
|                            | To To  | ~                 | 29b. Signature and title of certifier   | m ma  | \              |               | D 2   | 2-600               |   | 12/19         | 105                      | ,, ,/                           |           |
| •                          |  |                   | 30. Name and address of person w  | the completed cause of                            | death (Item    | 23a) (Type    | . Print)  | 30                  |   | 1             | 4                        |                                 |           |
|                            | 10+1   |                   | Kamruelm  | Mithani   | MO             | 116           | oe Rievo  | lution S            | t Harre                                       | De C          | oder                     | ms 3                            | 1078      |
|                            | Sta  | ite               | 31. Date filed (Month, Day, Year)   | 32 Registr  | rar's Signatu  | ure /         | adi s   |                     |   |               |                          |                                 |           |
|                            | Regist   | rar               | DEC 2 7   | 2005  | J. J.S.        | 1             |   |                     |   |               |                          |                                 |           |

|  | 1                          | For<br>State<br>Registrar  | State of Marylan  |   |                               | of Health and<br>of Death  | Mental Hy                               | giene<br>Reg. No. | 005                                       | 41908  |
|--|----------------------------|--|---|---|-------------------------------|--|---|-------------------|---|--|
| Physicia   | n                          | 1. Decedent's Name (First, Middle, Last) Ralph   | Donald  |   | Basili                        | 0  | 2. Date of Do<br>Month                  | Day               | Year<br>OS                                | 3. Time of Death   |
| /Medica<br>Examine<br>Funeral<br>Director  | r                          | 4a. Facility Name (If not institution, give s  ACTED MEAR- 5. Social Security Number 219-14-7239 6. Security Number  | + Haspital  | (ast birthday)<br>Yrs.                      | OU IY                         | wn, or Location of Dea<br>Der Q 10<br>Year If Under 24 Hrs<br>lays Hours Min | th  S. 8. Date of Bi                    | rth<br>ay, Year)  | Co  |  |
| how<br>dat   |                            | Usual Residence of Decedent 10a. State 10b. County   |   | y, Town or Lo                               |                               |  |   |                   |   | 10d. Inside City Limit                                   |
| Department of Health and Mental Hygiene, importent; or Items 23s or 28s-f show importent; if Item 27 is marked other than "natural; or Items 25s or 28s-f show eny injury or other traumatic event, the Medical Examinat must be notified at once. | Funeral Director           | MD Allegany  10e. Street and Number  2015 Mustaphal Driv   | re  | La  | aVale                         | ode 21502  |   |                   | ten of What Co                            | 1 ☐ Yes 2 ☒ N<br>untry?                                  |
| , or iteme 2:<br>carniner mus  | by Funera                  | 11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  | 12. Was Decedent Ever in U.<br>Armed Forces?<br>1 \\ Yes 2 \subseteq \text{No 1943}<br>If Yes, Give<br>Year or Dates: 19/15 | <b>3</b> -                                  | Was Deceder<br>f Yes, specify | t of Hispanic Origin? (<br>Cuban, Mexican, Pue<br>No <i>Specify:</i>         | Specify Yes or Norto Rican, etc.)       |                   | 4. Race - Ame<br>Black, White<br>Specify: |  |
| nen "natural<br>e Medical Ex   | Completed b                | 15. Decedent's Edu (Specify only highest grade   | cation<br>e completed)<br>College (1-4or 5+)  | 16a. Deced<br>(Give<br>life. L              | DO NOT use                    | done during most of wo<br>retired)   | orking                                  |                   | nd of Business/l                          | Industry   |
| ental Hygier<br>ced other th<br>c event, the   | To Be Cor                  | 12 17. Father's Name (First, Middle, Last) Romeo   | Basilio   | Own   | ner and                       | Operator  18. Mother's Na  Delcie  | me (First, Middle                       | e, Maiden :       |   | ore<br>ing   |
| alth and Me  | ř                          | 19a. Informant's Name/Relationship (Ty<br>Vicki A. Brashears /   |   |   | -                             | ew Drive, Fro  | lural Route Numb                        | per, City or      | Town, State, Z                            |  |
| ment of He<br>ent: If Item<br>lury or othe   |                            | 20a. Method of Disposition 1 ☐ Burial 2 【③Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)   | emoval from State Cum   | Place of Dispo<br>cometery, cren<br>berland | cremato                       | r place)<br>ry 12/19   | Date 9/2005                             | Cum               |   | Maryland   |
| Departiment Import   |                            | 21. Signatury of Juneral Service Licens  Service Licens  23a. Part1. Enter the disease, or compl   | doms  |   | 404 Dec                       | atur Street,   | Cumberlan                               | d, Mar            |   |  |
| ysician<br>Medical<br>aminer   |                            | shock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)  | Due to (or as a conseq  | Vasa  | in low                        | Accident<br>ATherosu   | 0                                       |                   |   | Interval Between<br>Onset and Death                      |
| physicien and the burial-transit   | dical Examiner             | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | Due to (or as a conseq  Due to (or as a conseq  |   |                               |  | ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, |                   |   |  |
|  | Completed by Physician/Med | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  | 3c. If yes, outcome of pregna<br>1 ☐ Live birth 2 ☐ Feta<br>4 ☐ Pregnant at time of d<br>9 ☐ Unknown                        | ildeath 3□                                  | Ectopic preg<br>Other (spec   |  |   | 2                 | 3d. Date of deli<br>Month                 | very<br>Day Year   |
| been signed b  | ed by Pt                   | Part II. Other significant conditions con  | ntributing to death but not res   | ulting in the ur                            | nderlying cau                 | se given in Part I.  | 1 .                                     | tobacco us        |   | the cause of death?                                      |
| cate hes been page 2 should  | Complet                    |  |   |   |                               |  | 24a. Was<br>auto<br>perf<br>1 Yes       |                   | prior to death?                           | topsy findings availab<br>completion of cause of<br>2 No |
| direct   | To Be                      | 25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No  | lospital:<br>1⊠Inpatient 2□   | ER/Outpatien                                | it 3 DOA                      | Other  | eath (Check only<br>Home 5 Res          |                   | ☐Other (Spec                              | cify)  |
| After t<br>funera  | Certification:             | 27. Manner of Death  1 🖾 Natural 5 🗆 Pending 2 🗀 Accident investigation 3 🖺 Suicide 6 🗀 Could not be   | 28a. Date of Injury<br>(Month, Day Year)  | 28b. Time of<br>Injury                      | м                             | Injury at<br>Work?<br>1 Yes 2 No   | 28d. Describe                           |                   |   |  |
|  |                            | 4 Homicide determined  | 28e. Ptace of Injury - At he building, etc. (Specification: To the best of my and   | <b>5</b> )                                  |                               |  | City or To                              | iwn, State)       |   | ral Route Number,  |
| within 24 hd<br>To the Fun<br>completely   | Medical                    |  | ner: On the basis of examina and manner stated.   |   | vestigation, in               | my opinion, death occ  | curred at the time                      | , date and        | place, and due                            | to the cause(s)  |
| 1 UA   |                            | 30. Name and address of person who or  | om Jaco cause of death (Item  | n 23a) (Type,                               | Print)                        | D1931  | 8                                       | (                 | Dec 1                                     | 5Th 2005   |
| Nhs<br>Stat  | e                          | DR , NAGARATNA 31. Date file Propriato   | n RANIHA  | AN 5  | 17 01                         | dtown F  | ROACI, (                                | unt               | perland                                   | d, md als  |

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death December 7, 2005 **Physician** Albert Andrew Brackna 7:15A. /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death County of Death Washington Adventist Hospital Takoma Park Montgomery 5. Social Security Number 6. Sex 1 M 2 □ F **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Aug. 2, 1915 9. Birthplace (State or Foreign Director 169-09-1643 90 Yrs. Pennsylvania Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

and: If item 27 is marked other than "naturat", or items 23a or 28a-1 show ury, or other traumatic event, it a Medical Evantive frout be redified at 10a, State 10b. Count 10c. City, Town or Location 10d. Inside City Limits Completed by Funeral Director Maryland Montgomery Silver Spring 1 ☐ Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20904 11621 New Hampshire Avenue, #221 United States 12. Was Decedent Ever in U.S. Armed Forces? 14DYes 2 □ No If Yes, Give Year or Dates: WWII 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No White Specify: 3X Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry US Government Elementary/Secondary (0-12) College (1-4or 5+) 5+ Dept. of Interior Budget Analyst 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Theodore Brackna Veronica Frankoski ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Gode) 13608 Duhart Road Germantown, Maryland 20874 9a. Informant's Name/Relationship (Type, Print) David A. Brackna -son 20a. Method of Disposition

✓ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Maryland Veterans Cem. 12/14/2005 Cheltenham, Maryland permit. Page Department of Important: If any injury or once. \* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fundal Se vice License Dőnald V. Borgwardt Funeral Home, PA 4400 Powder Mill Road Beltsville, Maryland 20705 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transit HROWIC Due to (or as a consequence of); Division of Vital Records, P.O. Box 68760. physician Physician/Medical the attending IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 XNo 3 ☐ Probably 4 ☐ Unknown Be Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No has autopsy performed? Yes 2 \(\sigma\)\(\text{Vo} certificate 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner' 1 ☐ Yes 2 ☐ No Cther: 4 Nursing Home 5 Residence 6 Other (Specify) ٩ 1 7 patient this 2 ☐ ER/Outpatient 3 ☐ DOA in by the funeral Certification: 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending death. 2 Accident investigation 1 ☐ Yes 2 ☐ No after death 6 Could not be determined 3 🔲 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) D4696 12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

STWW TU, MD 3415 HAMILTONS 31. Date filed (Month, Day, Year)

DEC 1 2 Registrar's Signature State Registrar

|                               |   |                | 1 - State<br>Registrar  | State of M  | larylan         |  |  | nt of H<br>te of L                 |                             | nd Me                | -                               | giene<br>Reg. No.    | 005                        | 1,1910   |     |
|-------------------------------|---|----------------|---|---|-----------------|--|--|------------------------------------|-----------------------------|----------------------|---------------------------------|----------------------|----------------------------|--|-----|
|                               | Physici   | an             | Decedent's Name (First, Middle, I   | •   |                 |  |  |                                    |                             |                      | 2. Date of De                   | Day                  | Yea                        | 3. Time of Death                                       |     |
|                               | /Medic  |                |   | OCK   |                 |  |  |                                    |                             | <u>_</u>             | Decemb                          | er 9                 | ,2005                      | 5;00 A   | 1   |
|                               | Examin  | er             | 4a. Facility Name (If not institution, g  |   | )               |  |  |                                    | Location of                 |                      |                                 |                      | County of De               |  |     |
|                               |   |                | Holy Cross Hos  5. Social Security Number 6.  |   | ne (In vrs.     | last birthday)                         |  | r 1 Year                           | Spri                        | 4 Hrs                | 8. Date of Bir                  | 45                   | ontgom                     |  | 771 |
|                               | Funeral<br>Director   |                | 219-26-3158   | 1 <b>X</b> M 2□ F   | 70              | Yrs.                                   | Months   | Days                               | Hours                       | Min.                 | (Month, Da<br>Sept.9            | 19, Year)            | 5 C                        | Birthplace (State or Foreig<br>Country)<br><b>hina</b> | • • |
|                               | D   |                | Usual Residence of Decedent   |   |                 |  |  |                                    |                             |                      |                                 | , - , - ,            |                            |  |     |
|                               | arylar<br>ehow  | _              | 10a. State 10b. County  |   |                 | y, Town or Lo                          | cation   |                                    |                             |                      |                                 |                      |                            | 10d. Inside City Limits                                |     |
|                               | 8a-f  | ecto           | Md. Montgo  | mery  |                 | Boyds                                  | 1  |                                    |                             |                      | -                               |                      |                            | 1 ☐ Yes 2 🔯 No   |     |
|                               | with t  | 눔              | 10e. Street and Number  |   |                 |  | 107. 2   | ip Code                            | 0.41                        |                      |                                 | -                    | zen of What                | •  |     |
|                               | ns 23   | eral           | 14110 Bear Cree   | k Drive   | Ever in U.      | S. 13.V                                | Was Dec  |                                    | 841                         | in? (Spec            | ify Yes or No                   |                      | ted St                     | ates   |     |
| 36                            | permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23s or 28s-f show any injury or other traumatic event, the Medical Exprired must be notified at once. | by Fun         | 1 ☐ Never Married 2 ∰ Married<br>3 ☐ Widowed 4 ☐ Divorced   | Armed Forces  | ?<br>'No        | 1                                      |  | ecify Cubai<br>2∏ No               | n, Mexican,<br>Specify:     | Puerto P             | cify Yes or No<br>Rican, etc.)  | 1                    | Black, W<br>Specify:       | hite, etc.   |     |
| ğ                             | 2 hou   | ted            | 15. Decedent's  | Education   |                 | 16a. Deced                             |  |                                    |                             | -4 - 4:              |                                 | 16b. Kir             | nd of Busine               | ss/industry  |     |
| 215                           | thin 7  | ple            | (Specify only highest of Elementary/Secondary (0-12)  | College (1-4or  | 5+)             | Inter                                  | <sup>King</sup> of W<br>DO NOT<br>na <b>ti</b> | ork done d<br>use retired,<br>on a | Trade                       | of workin            | g                               | U.S                  | . Stat                     | e  |     |
| 7                             | ed wil  | Con            |   | 5+  |                 | Spec                                   | iali   | st                                 |                             |                      |                                 |                      | artmen                     | t  |     |
| altimore, Maryland 21215-0036 | wuld be fill<br>Mental Hy<br>arked oth  | To Be          | 17. Father's Name (First, Middle, La<br>Nelson Bock   | st)   |                 |  |  |                                    |                             |                      | (First, Middle<br>Lau           | , Maiden             | Sumame)                    |  |     |
| Mar                           | and 2 sho<br>alth and<br>27 is mu<br>er traum   |                | 19a. Informant's Name/Relationship Julia S. Bock  | (Type, Print)<br>(Wife)   |                 |  |  |                                    |                             |                      | Route Numb<br>Boyd              |                      |                            |  |     |
| more                          | Pages 1 :   |                | 20a. Method of Disposition  1 □ Burial 2 X Cremation 3  4 □ Donation 5 □ Other (Special Control of the Control |   | ,   0           | Place of Disponentery, crent<br>ropoli | natory or                                      | other place                        |                             | Dec.<br>200          |                                 |                      | cation - City              | or Town, State   |     |
| Balti                         | permit. Departm Imports any inju  |                | 21. Signature of Funeral Service Lic  |   |                 |  |  |                                    |                             | DeV                  | ol Fun                          | eral                 | Home                       | Md. 20877  | 1   |
|                               |   |                | 23a. Part1. Enter the disease, or co<br>shock, or heart failure. List on  | mplications that cause  | d the death     |  |  |                                    |                             |                      |                                 |                      |                            | Approximate<br>Interval Between                        |     |
|                               | Physician   |                | Immediate Cause (Final disease or condition   | Panhyp  |                 |  |  |                                    |                             |                      |                                 |                      |                            | Onset and Death  |     |
|                               | /Medical  |                | resulting in death)   | Due to (or as   |                 |  | ***  |                                    |                             |                      |                                 |                      |                            |  | _   |
|                               | Examiner  |                | Sequentially list conditions.   | b   |                 |  |  |                                    |                             |                      |                                 |                      |                            |  |     |
|                               | Sit ad  | Examiner       | Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury  | Due to (or as   | a conseq        | uence of                               |  |                                    |                             |                      |                                 |                      |                            | 1  |     |
|                               | and<br>I-tran   | xarr           | that initiated events resulting in death) Last  | c. Due to (or as  | a consen        | nence of):                             | -  |                                    |                             | _                    |                                 |                      |                            | -  |     |
| 8760,                         | ficate be executed<br>physician and<br>is the burial-transit  | dlcai E        | •   |   |                 |  |  |                                    |                             |                      |                                 |                      |                            |  |     |
| 687                           | ficate<br>physics the   | edic           |   | d   |                 |  |  |                                    |                             |                      |                                 |                      |                            |  |     |
| Вох                           | eath certific<br>attending pl<br>for use as t   | N/M            | IF FEMALE:<br>23b. Was decedent pregnant  | 23c. If yes, outcome  |                 |  |  |                                    |                             |                      |                                 | 2                    | 3d. Date of o              | delivery   |     |
| P.O. B                        | The law requires that the death certificate be executed tie hes been signed by the attending physician and page 2 should be detached for use as the burial-transit  | Physician/M    | in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown   | 1□Live birth<br>4□Pregnant a<br>9□Unknown                       |                 |  | Ectopic  <br>Other (s                          | pecify)                            |                             |                      |                                 |                      | Month                      | Day Year   |     |
| <u>ر</u> ر<br>ت               | res that<br>igned b<br>be deta  | by PI          | Part II. Other significant conditions   | contributing to death   | out not resi    | ulting in the ur                       | nderlying                                      | cause give                         | n in Part I.                |                      | 23e. Did t                      | obacco us            | se contribute              | to the cause of death?                                 |     |
| ğ                             | w require<br>been sig<br>should b   | ed t           |   |   |                 |  |  |                                    |                             |                      | 10                              | Yes 2[               | ]No 3□                     | Probably 4 X Unknown                                   | 1   |
| ပ္ပ                           | aw requ<br>ss been<br>2 shoul   | Completed      |   |   |                 |  |  |                                    |                             |                      | 24a. Was                        |                      | 24b. Were                  | autopsy findings available                             | 9   |
| Ĕ                             | The lav<br>ete hes<br>page 2 :  | ĕ              |   |   |                 |  |  |                                    |                             |                      | autor<br>perfo                  | ormed?               | death                      | o completion of cause of<br>?<br>es 2□ No              |     |
| ita                           | ysician: The is certificate he director, page   | Be             | 25. Was case referred to medical examiner?  | 1   |                 |  |  |                                    | 26. Place o                 | of Death             | Check only                      |                      |                            |  |     |
| <u>&gt;</u>                   |   | ၉              | 1 ☐ Yes 2X No   | Hospital:   |                 | ER/Outpatien                           |  |                                    | 4 🗀 INUIS                   | sing Hom             | e 5 🗌 Resi                      | dence 6              | Other (S)                  | pecify)  |     |
| Ĕ                             | Attending Physician:<br>r death.<br>ector: After this certifice<br>by the funeral director, p   | ë<br>ë         | 27. Manner of Death 1 ☑ Natural 5 ☐ Pending   | 28a. Date of Inju   | ury<br>ay Year) | 28b. Time of<br>Injury                 | - 1  | 28c. Injury<br>Work                |                             |                      | Bd. Describe                    | how injury           | occurred                   |  |     |
| <u>s</u>                      | ttend<br>death<br>tor: /<br>the f   | cat            | 2 Accident investigat 3 Suicide 6 Could not   | he  | A46.            |  | М  |                                    | ∕es 2∏N                     |                      | 26 1 1 1                        | <u> </u>             |                            |  | _   |
| Division of Vital Records,    | i Si ji e   | Certification: | 4 Homicide determine  | building, e   | tc. (Specify    | y)<br>                                 |  |                                    |                             |                      | City or To                      | wn, State)           |                            | Rural Route Number,                                    | ļ   |
|                               | To the Hospital or Attending Ph within 24 hours after death.  To the Funeral Director: After th completely filled in by the funeral   | edical         | 29a. Certifier 1X Certifying I<br>(Check only 21 Medical Ex-  | hysician To the best<br>miner: On the basis of<br>and manner st | of examina      | wledge, death<br>tion and/or inv       | occurre<br>estigatio                           | d at the tim<br>n, in my op        | e, date and<br>inion, death | place, ar<br>occurre | nd due to the<br>d at the time, | cause(s)<br>date and | and manner<br>place, and d | as stated.<br>ue to the cause(s)                       |     |
|                               | withi<br>To th  | Σ              | 29b. Signature and title of dediffier   | $\vee$  |                 |  | 25   | c. License                         |                             |                      |                                 |                      |                            | nth, Day, Year)  |     |
| •                             | 20  |                | · XOX   | 7   |                 |  |  | D006                               | 2885                        |                      |                                 | De                   | cember                     | 9, 2005  |     |
|                               |   |                | 30. Name and address of person who Dr. S. Wyche M. D  | 1.  |                 |  |  | Silv                               | er Sp                       | ring                 | , Md.                           | 2091                 | 0                          |  |     |
|                               | Sta<br>Registr  |                | 31. Date filed (Month, Day, Year) DEC 12  | 32 Regist   | rar's Signa     |  | Mes.   |                                    |                             |                      |                                 |                      |                            |  |     |

|                     |   |                  | = For AMEND#23a-IIperMD12/12/05, BW,MCC<br>  = State<br>Registrar AMEND#23a(b)perMo12/12/05, BW,M                               | d / Depa<br>bco <i>Cer</i> | artment of H                             | lealth and Me<br>D <i>eath</i>                  | ntal Hygien                              | e<br>2005                       | 41911   |
|---------------------|---|------------------|---|----------------------------|--|---|--|---------------------------------|---|
| 1.0                 | Maria John R.   |                  | Decedent's Name (First, Middle, Last)   |                            |  |   | Date of Death                            |                                 | 3. Time of Death                                |
|                     | Physicia<br>/Medic  |                  | Herbert Wynne Black   |                            |  |   | 12 -                                     | 2-2005                          | 100 P.M   |
|                     | Examin  |                  | 4a. Facility Name (If not institution, give street and number) Union Memorial Hospital  |                            | 4b. City, Iown, or<br>Baltim             | Location of Death<br>ore City                   | 4  | tc. County of Death<br>NONE     | 1   |
|                     | Funeral<br>Director   |                  | 5. Social Security Number 6. Sex 7. Age (In yrs. 1) M 2 F   | 1ast birthday)<br>75 Yrs.  | If Under 1 Year<br>Months Days           | Hours Min. Ma                                   | Date of Birth<br>Month Day<br>193        | 9. Birth<br>Penn                | nplace (State or Foreign<br>intry<br>Sylvania   |
| 1000                | ۳ ,   |                  | Usual Residence of Decedent  10a. State 10b. County 10c. Cit  | y, Town or Loc             | antion                                   |   |  |                                 | 10d. Inside City Limits                         |
|                     | aryla<br>•hov   | 5                |   | Seaford                    |  |   |  |                                 | 1 Yes 2X No                                     |
|                     | 28e-1   | rect             | 10e, Street and Number  |                            | 10f. Zip Code                            |   | 10g. 0                                   | Citizen of What Cou             | untry?  |
|                     | 3a or   | Funeral Director | 7777 Grace Circle   |                            | 199                                      | 973   |  | United :                        | States  |
|                     | ems a   | ner              | 11. Marital Status 12. Was Decedent Ever in U   |                            | Was Decedent of H<br>I Yes, specify Cuba | spanic Origin? (Speci<br>in, Mexican, Puerto Ri | y Yes or No-<br>can, etc.)               | 14. Race - Amer<br>Black, White |   |
| 36                  | be filed within 72 hours after death with the Maryland ital Hygiene. Id other than "natural", or items 23s or 28e-1 show event, the Medical Examment into the modified at | by FL            | 1 Never Married 2 Married 1 Yes 2 No If Yes, Give 1948 – 1  | 1952 1                     | 1□Yes 2X No                              | Specify:  |  | Specify: W                      | hite  |
| 9                   | 2 hour  | ted t            | 15. Decedent's Education  | 16a, Deced                 | lent's Usual Occup                       | ation   | 16b.                                     | Kind of Business/li             | ndustry   |
| 215                 | within 72<br>ene.<br>than "nal  | Completed        | (Specify only highest grade completed)  Elementary/Secondary (9·12) College (1·4or 5+)  | life. C                    | DO NOT use retired                       | •   |  |                                 | 7.4   |
| 21                  | filed wii<br>Hygien<br>sther th   |                  | 12  | Lead                       | Aircraf                                  | t Mechanic  18. Mother's Name (                 |  | Inited Air                      | rlines  |
| Maryland 21215-0036 | uld be fi<br>Jental H<br>rked otl   | To Be            | 17. Father's Name <i>(First, Middl</i> e, Last)<br>William Maurice Black  |                            |  | Alberta   | TISI, WIIGGIƏ, WAIG                      | Wynne                           |   |
| ary                 | shoul<br>and M<br>s mari  |                  | 19a. Informant's Name/Relationship (Type, Print)  | L.                         | -  | and Number or Rural R                           |  |                                 |   |
|                     | and 2<br>lealth<br>m 27 I   |                  | Shirley L. Black -wife  |                            | Grace Cil                                | ccle Seafor                                     |  | are 1997.                       |   |
| Baltimore,          | Pages 1 and 2 should brinent of Health and Mentstent: If item 27 is marked lury or other treumatice   |                  | 200 Barriel Commention 2 Demonstrate State  | cemetery <u>,</u> cren     | natory or other place<br>eaven Cer       | (0)   |  |                                 | ng,Maryland                                     |
| Balti               | Departm<br>Departm<br>Imports<br>any inju   |                  | 21. Signature of Funeral Service Licenson   | D <del>3</del>             | naitand<br>00 Powdei                     | Sorgwardt I<br>Mill Road                        | Tuneral H<br>1 Beltsvi                   | lome, PA<br>11e, Mar            | yland 20705                                     |
|                     | 30  |                  | 23a. Part1. Enter the disease, or complications that caused the deat shock, or heart failure. List only one cause on each line. |                            |  |   |  |                                 | Approximate<br>Interval Between                 |
|                     | Physician   |                  | Immediate Cause (Final disease or condition   | Kespin                     | ratury &                                 | )15/ress >                                      | yadom                                    | .e                              | Onset and Death                                 |
|                     | /Medical<br>Examiner  |                  | resulting in death)  Due to (or as a consect Aspiration   |                            | onia                                     |   | ι  |                                 | 7 = V = 0                                       |
|                     |   | er               | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury                     | uence ol):                 | †  | . 0   | 1 /                                      |                                 | 200   |
|                     | cuted<br>Ind<br>ransit  | Examlne          | that initiated events   | 10 -e                      | soph ago                                 | eal Kisi  | tula                                     |                                 | YWK   |
| 90,                 | sicien and<br>burial transit  | I Ex             | resulting in death) Last  Due to (or as a consequence)  | ī                          | su +                                     | - Mal-  | Lack-                                    | _                               | Lik   |
| 68760               | icate be ex<br>physicien<br>s the burial  | dical            | d. Esopha   | 1 200                      | 7  | . (40 )(-)                                      |  |                                 | Cuc   |
| Box (               | eath certific<br>attending p  | n/Me             | IF FEMALE: 23b. Was decedent pregnant 1 □Live birth 2 □ Fete  | ancy                       | Ectopic pregnancy                        |   |  | 23d. Date of deliv              |   |
|                     | at the deatl<br>by the atte   | Physician/Me     | n the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 9 ☐ Unknown  |                            | Other (specify)                          |   |  | Month                           | Day Year  |
| s, P.O.             | res that t<br>igned by<br>be detac  | by Ph            | Part II. Dther significant conditions contributing to death but not res   | ulting in the ur           | nderlying cause giv                      | en in Part I.                                   | 23e. Did tobacc                          | o use contribute to             | the cause of death?                             |
| ord                 | w require<br>been sig<br>should b   | ted              | Malnutrition  |                            |  |   | 1 🗆 Yes                                  | 2 No 3 □ Pro                    | obably 4 [Unknown                               |
| Vital Records,      | The law requires that the death certificate be executed tables been signed by the attending physicien and page 2 should be detached for use as the buriat-transit         | ompleted         |   |                            |  |   | 24a. Was an<br>autopsy<br>performed      | prior to c<br>death?            | topsy findings available completion of cause of |
| ital                |   | ၁                | 25. Was case referred to medical  |                            |  | 26. Place of Death (                            | 1 ☐ Yes 2 ☐ ☐ Check only one)            | 10 105                          | 2010  |
|                     | Physician:<br>this certific<br>ral director,  | To B             |   | ER/Outpatien               |  | 4   Nursing Home                                |  | 6 □Other (Spec                  | afy)  |
| ou c                | fter<br>Ter   | lon:             | 27. Manner of Death  ☐ Matural 5 ☐ Pending ☐ Month, Day Year) ☐ Month, Day Year)  | 28b. Time of<br>injury     | Wor                                      | yat<br>k?<br>Yes 2 □ No                         | d. Describe how in                       | jury occurred                   |   |
| Division of         | To the Hospital or Attending within 24 hours after death, a To the Funeral Director: After completely filled in by the fune.  | Certification:   | 2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At h building, etc. (Speci                  |                            |  |   | f. Location (Street<br>City or Town, Sta | and Number or Ru<br>ate)        | ral Route Number,                               |
| Ω                   | Hospital of the hours of Funeral Ditely filled in   |                  | 29a. Certifier tSC Certifying Physician: To the best of my known  |                            |  |   |  |                                 |   |
|                     | the Ho<br>in 24 }<br>the Fu<br>ipletely   | Medical          | (Check only one) Ž Medical Examiner: On the basis of examination and manner stated.   | ation and/or inv           | ,  |   |  |                                 |   |
|                     | To the To the complet   | 2                | 29b. Signature and title of certifier  MD   |                            | 29c. Licens                              | 43894   | 290.1                                    | Date signed (Month              | y vay, rear)                                    |
|                     | 12  |                  | 30. Name and address of person who completed cause of death (itel   | m 23a) (Type,              | Print)                                   |   |  | 11                              | , ,,,   |
| 12                  | Sta   | to <sup>a</sup>  | 1) a thank! Muhune y 31. Date liled (Month, Day, Year) 32. Figistrar's fign   | ature erusa                | UNIVE                                    | n Mem   | orral (                                  | tospota                         | 1,000   |
| 3                   | Registi   |                  | DEC 1 2 2005  | IF A                       | geres.                                   |   |  |                                 |   |

|                     |   |                         | For State Registrar   | State of M                                       |                      | d / Depa               |                            | t of H             | ealth a   | and M       | ental Hyg  |               | 0.00                        | 1.1912   |
|---------------------|---|-------------------------|---|--|----------------------|------------------------|----------------------------|--------------------|---|-------------|--|---------------|-----------------------------|--|
|                     |   |                         | Registrar     Decedent's Name (First, Middle, L.)   | a at l   |                      |                        | uncau                      | GOIL               | Jean  |             | 2. Date of Deat  |               | 000                         | 3. Time of Death                                   |
|                     | Physici   | an                      |   | •  |                      |                        |                            |                    |   |             | Month  | Day           |                             |  |
|                     | /Medic  |                         |   |  |                      | SR.                    |                            |                    |   |             | Decembe  | $\overline{}$ |                             | 2:02 P <sup>M</sup>                                |
|                     | Examin  | er                      | 4a. Facility Name (If not institution, g.   | ive street and number)                           | 1                    |                        | 4b. City,                  | Town, or           | Location of   | of Death    |  | 4c. 0         | County of Dea               | th   |
|                     |   |                         | Garrett County M  |  |                      |                        |                            |                    | akla  |             |  |               | Garı                        |  |
|                     | Funeral   |                         | Social Security Number     6.   | Sex 7. Ag  | ge (In yrs.          | last birthday)         | If Under<br>Months         |                    | If Under<br>Hours   | Min.        | <ol><li>Date of Birth<br/>(Month, Day,</li></ol>   | Year)         | 9. Bir                      | thplace (State or Foreign ountry)                  |
|                     | Director  |                         | 214462878   | IMM ZUF  | 64                   | Yrs.                   |                            |                    |   | S           | Sept. 23   | , 19          | 941 Ma                      | aryland  |
|                     | D .   |                         | Usuel Residence of Decedent   |  | 10- 04               | y, Town or Lo          | netice.                    |                    |   |             |  |               |                             | 10d. Inside City Limits                            |
|                     | tryla:  | L                       | 10a. State 10b. County  |  | TOC. CIT             | y, Town or Lo          | cation                     |                    |   |             |  |               |                             | 1 Yes 21 No  |
|                     | Ra-f.   | cto                     | MD Ga   | rrett  |                      |                        | 0a                         | ıklar              | ıd  |             |  |               |                             | 1 103 220110                                       |
|                     | 5 7 3 E   | ire                     | 10e. Street and Number  |  |                      |                        | 10f. Zip                   | Code               |   |             | 10   | 0g. Citiz     | en of What C                | ountry?  |
|                     | 23a   | al                      | 2911 Oakland-San  | g Run Road                                       |                      |                        |                            |                    | 21550   | 0           |  |               | USA                         | A  |
|                     | dea   | <b>Funeral Director</b> | 11. Marital Status  | 12. Was Decedent<br>Armed Forces                 |                      | .S. 13.                | Was Deced                  | dent of Hi         | spanic Ori  | gin? (Spe   | cify Yes or No-<br>Rican, etc.)  | 1             | 4. Race - Ame<br>Black, Whi |  |
| 9                   | after<br>or Ite   | 正                       | 1 ☐ Never Married 2X Married  |  |                      | -                      | 1 □ Yes                    |                    |   |             | nour, oto.,  |               |                             |  |
| සි                  | within 72 hours after death with the Maryland<br>ene.<br>then "naturel", or Items 23a or 28a-f show<br>he Medical Exam are must be invitted at  | by                      | 3 ☐ Widowed 4 ☐ Divorced  | Year or Dates:                                   |                      |                        | 1 🗆 1 03                   | 2 22 140           | opocity.  |             |  | ,             | Specify:                    | White  |
| Maryland 21215-0036 | 72 hg   | tec                     | 15. Decedent's (Specify only highest g  | Education  |                      | 16a. Dece              | dent's Usua                | al Occupa          | ation   | t of workir | ng .   | 16b. Kin      | d of Business               | /Industry  |
| 2                   | thin en   | ple                     | Elementary/Secondary (0-12)   | College (1-4or                                   | 5+)                  | life.                  | kind of wo<br>DO NOT us    | se retired         | )   |             | .9   |               |                             |  |
| 2                   | e filed within<br>al Hygiene.<br>I other then vent, the My  | Completed               | 9th   |  |                      | Heav                   | y Equ                      | iipme              | nt O  | perat       | or   | Cons          | structi                     | Lon Company  |
| פ                   | oth<br>vent   | Be (                    | 17. Father's Name (First, Middle, Las   | st)  |                      |                        |                            |                    | 18. Mothe   | er's Name   | (First, Middle, N  | Maiden S      | Sumame)                     |  |
| <u> </u>            | denta<br>denta<br>rked<br>rice  | To E                    | Wilbur Arno   | 1d Bow   | ser                  |                        |                            |                    | Mar   | ie          | Marga  | ret           | Si                          | Lmmons   |
| ary                 | perrit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: if item 27 is merked other then "naturel", or Items 23a or 28a-f show any njurry or other treumatic event, the Mydfaal Exant act must be nytified at once. | _                       | 19a. Informant's Name/Relationship  | (Type, Print)                                    |                      | 19b. Maili             | ng Address                 | (Street a          | and Numbe   | er or Rura  | l Route Number,  | City or       | Town, State,                | Zip Code)  |
|                     | nd 2<br>lith a<br>27 is   |                         | Viola M. Bowse  | r/wife   |                      | 2911                   | 0ak1                       | and-               | Sang  | Run         | Road, O  | ak1a          | and. Mo                     | 1. 21550   |
| Baltimore,          | Hea<br>Hea<br>tem   |                         | 20a. Method of Disposition  | •  | 20b. F               | Place of Dispo         | sition (Nar                | ne of              |   |             |  |               | ation - City or             |  |
| 2                   | ages<br>nt of<br>t: # i   |                         | 1 ☑ Burial 2 ☐ Cremation 3 14 ☐ Donation 5 ☐ Other (Spec  |  | 1                    | cemetery, crei         |                            |                    | ,   | 10/11       | 1/05   | 1 7           | 1 1/                        | 1  |
| <b>=</b>            | it. P   |                         | 21. Signature of Funeral Service Lic  |  | The                  | yervi]                 | 2. Name an                 |                    |   |             | The state of the s |               | and, Mo                     |  |
| Ba                  | Departing on the series   |                         | 21. Signature of Cinetal Control Do   | 1  |                      |                        |                            |                    |   | •           |  |               | Second                      |  |
|                     |   |                         | - Stockery 13   |  | 444                  |                        | tewar                      |                    |   |             |  |               | nd, Md.                     | 21550  |
| L                   |   |                         | 23a. Part1. Enter the disease, or co shock, or heart failure. List on   | mplications that cause<br>ly one cause on each l | d the deat<br>ine.   | n. Do not en           | er the mod                 | e ot dylne         | g, such as  | cardiac o   | r respiratory arre   | est,          |                             | Approximate<br>Interval Between<br>Onset and Death |
| 4                   | Priysician  |                         | Immediate Cause (Final disease or condition   | Live   | Fai                  | lure                   |                            |                    |   |             |  |               |                             | 4 Days   |
|                     | /Medical  |                         | resulting in death)   | Due to (or as                                    | a conseq             | uence of):             |                            |                    |   |             |  |               |                             |  |
|                     | Examiner  |                         | Conventially list and disings   | b. Carci   | Lnoma                | tosis                  |                            |                    |   |             |  |               |                             | Macki  |
|                     |   | Jer                     | if any, leading to immediate  | Due to (or as                                    | a conseq             | uence of):             |                            |                    |   |             |  |               |                             |  |
|                     | uted<br>d<br>ansi   | Examiner                | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events | Gasti  | ric a                | nd Col                 | on Ca                      | ncer               |   |             |  |               |                             | Weeks  |
| Ć                   | be executed<br>sician and<br>burial-transit   | EX                      | resulting in death) Last  | Due to (or as                                    | a conseq             | luence of):            |                            |                    |   |             |  |               |                             |  |
| 760,                | ysicia<br>ysicia  | cal                     |   | d.   |                      |                        |                            |                    |   |             |  |               |                             |  |
| 89                  |   | edi                     |   |  |                      |                        |                            |                    |   |             |  | 1             |                             |  |
| Вох                 | death certifica<br>e attending ph<br>ed for use as th   | 2                       | IF FEMALE:<br>23b. Was decedent pregnant  | 23c. If yes, outcome                             |                      |                        | 75                         |                    |   |             |  | 2             | 3d. Date of de              | livery   |
| Ď                   | death<br>atte   | cia                     | in the past 12 months?  | 1 □Live birth<br>4 □ Pregnant a                  |                      |                        | ⊒Ectopic pr<br>⊒ Other (sp |                    |   |             |  | +             | Month                       | Day Year   |
| 0                   | 0 0 0   | Physician/M             | 9 Unknown   | 9□ Unknown                                       |                      |                        |                            |                    |   |             |  |               |                             |  |
| <u>C</u>            | The law requires that the de<br>ste has been signed by the a<br>bage 2 should be detached t   |                         | Part II. Other significant conditions   | contributing to death                            | but not res          | ulting in the u        | nderlying c                | ause give          | en in Part I  |             | 23e. Did tob   | acco us       | e contribute t              | o the cause of death?                              |
| Records,            | signe<br>d be   | d by                    |   |  |                      |                        |                            |                    |   |             | 1 □ Ye   | s 25          | No 3□P                      | robably 4 Unknown                                  |
| Ö                   | w require<br>been si<br>should b  | Completed               |   |  |                      |                        |                            |                    |   |             | -  |               |                             |  |
| ec                  | e law<br>has t<br>je 2 s  | ldu                     |   |  |                      |                        |                            |                    |   |             | 24a. Was ai<br>autops  | У             |                             | utopsy findings available completion of cause of   |
|                     |   | Sor                     |   |  |                      |                        |                            |                    |   |             | perform<br>1 ☐ Yes 2   | No            |                             | s 2 No   |
| Vital               | Physicien: Th<br>this certificate<br>ral director, pag  | Be                      | 25. Was case referred to medical examiner?  | 81   |                      |                        |                            |                    |   |             | (Check only on   |               |                             |  |
| of V                | nysic<br>nis ce   | 2                       | 1 ☐ Yes 2 💢 No  | Hospital:<br>1 X Inpat                           | ient 2               | ER/Outpatie            | nt 3 DC                    | Othe Othe          | <sup>9</sup> Γ: 4 □ Nu  | irsing Hon  | ne 5 🗌 Reside  | nce 6         | □Other (Spe                 | ecify)   |
|                     |   | ü.                      | 27. Manner of Death 1 XNatural 5 ☐ Pending  | 28a. Date of Inj<br>(Month, D.                   | ury<br>ay Year)      | 28b. Time of<br>Injury | if 2                       | 8c. Injury<br>Work | at<br></td <td>2</td> <td>28d. Describe ho</td> <td>w injury</td> <td>occurred</td> <td></td> | 2           | 28d. Describe ho   | w injury      | occurred                    |  |
| <u>.</u>            | uttendir<br>death.<br>ctor: Af<br>y the fu  | atic                    | 2 ☐ Accident investigat   |  |                      |                        | М                          | 1 🗆 '              | Yes 2□  | No          |  |               |                             |  |
| Division            | el or Attendii<br>s after death.<br>el Director: A<br>ed in by the fu   | Certification:          | 3 ☐ Suicide 6 ☐ Could not determine   |  | jury - At h          | ome, farm, st          | reet, factory              | y, office          |   | 2           | 8f. Location (St.<br>City or Town  |               | Number or A                 | lural Route Number,                                |
| Ö                   | el or<br>s afte   | Seri                    | - I Homeloo   | bunding, e                                       | ite. (Dpson          | · <b>y</b> /           |                            |                    |   |             | o., o o  | , oldio,      |                             |  |
|                     | To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the fune   | al C                    | 29a. Certifier 1 Certifying   | Physicien: To the besi                           | t of my kno          | owledge, deat          | h occurred                 | at the tim         | ne, date an   | nd place, a | and due to the ca  | iuse(s) a     | and manner a                | s stated.  |
|                     | HC HC S4  | ledical                 | (Check only 2 Medical Ex  | ammer: On the basis and manner s                 | of examina<br>tated. | ation and/or in        | vestigation                | , in my op         | oinion, dea   | ith occurre | ed at the time, da   | ate and p     | place, and du               | e to the cause(s)                                  |
|                     | o th<br>ithir<br>o th<br>omp  | Me                      | 29b. Signature and title of certifier   | NAC  | $\overline{}$        |                        | 290                        | c. License         | number  |             | 25   | d. Date       | signed (Mon.                | th, Day, Year)                                     |
|                     | F- >F- 0  |                         | 1   | 1/1)   |                      |                        |                            |                    | D5156   | 4           |  | 12            | /9/200                      | 5  |
| 7                   |   | . 4                     | 20 Name and address of  | o completed carres of                            | death /lic-          | m 23a\ /T              | Drine)                     |                    |   |             |  |               | , , , 200                   |  |
|                     | 10  |                         | 30. Name and address of son wh  |  |                      |                        |                            | 0.1.1              | t an  | M           | n tent   | 1550          |                             |  |
|                     | -   | 7000                    | Ihor Zakaluzny 31. Date filed (Month, Day, Year)  | , MD 31.   |                      | <u>hian A</u><br>ature | ٠,٧٢٠                      | Oakl               | ctila,  | nary        | Tand Z   | טכני          |                             |  |
|                     | Sta<br>Regist   |                         | DEC 1 4   | 2005   |                      | 40                     | 4.                         |                    |   |             |  |               |                             |  |
|                     | riegist   | -GI                     |   | AND SOUTH  | Post of              | 11 1                   | 14 2 304                   | Ĥ.                 |   |             |  |               |                             |  |

#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 7,2005 Krown Helen Rosa 11:50 AM December 4b. City, Town, or Location of Death 4a Fecility Name (If not institution, give street end number) 4c. County of Death Buklond Oatland Narsing and Rehabilitation Center Garrett If Under 1 Year Months Days If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex Months Hours 1 ☐ M 2 😾 F WV Feb 5 1931 214 62 2758 Usuel Residence of Decedent 10d. Inside City Limits 10a. Stete 10b. County 10c. City. Town or Location 1 ☐ Yes 2 ☐ No Gormania WV Grant 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 26720 USA Rtl Box 295 B Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U,S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married White 1 Yes 2 TNo Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaking Housewife 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Estell Hart Robert Paxton 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 26720 Rtl Box 205 B Gormania, WV William Brown 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 12/10/05 Bayard XV 4 ☐ Donation 5 ☐ Other (Specify) **Bayard Cemetery** 22. Name and Address of Fecility Burdock-Durst FH 21. Signature of Funeral Service Licensee Oakland, MD 21 N. 2nd St. wdou 23a. Perf1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, stock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in deeth) 2 weeks years em physema Sequentially list conditions, if eny, leeding to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 XYes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy

**Physician** /Medical Examiner

**Physician** 

/Medical

Examiner

Director

Funeral

Š

Completed

Be

ဥ

**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours aftar death with the Maryland Department of Health and Mental Hygiena. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event the

altimore, Maryland 21215-0020

Examiner attanding physician and for use as the burial-transit Physician/Medical \$ Completed To the Hospital or Attending Physician: The law within 24 bours aftar death.
To the Funeral Director: After this certificata has completaly filled in by the funeral director, page 2. Be 2 Certification:

The law requiras that tha death certificate be executed

Box 68760.

Division of Vital Records, P.O.

athersoleratic cardiovascular 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 M Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2√ No 28b. Time of 28d. Describe how injury occurred 27. Menner of Death 28e. Date of Injury (Month, Dey Year) 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide 12 Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) end manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

MD 30. Name end eddress of person who completed cause of deeth (Item 23a) (Type, Print)

B0x247 MD. K. Naumann.

29c. License number

State Registrar

Medical

31. Dete filed (Month, Day, Year)

29b. Signature end title of certifier

29a. Certifier

32. Registrar's Signature

2005

|                            |  |                  | For  | State of Marylar   |  |  |  | ntal Hygier                          | ne                                 |   |
|----------------------------|--|------------------|--|--|--|--|--|--------------------------------------|------------------------------------|---|
|                            |  |                  | State Registrer  |  | Certifi                                    | cate of De                               | eath                                     | Reg.                                 | Vo. 1 1 5                          | 1.1911.                                     |
|                            | Physici  | an               | Decedent's Name (First, Middle, L                                      | ast)   |  |  |  | . Date of Death Month                | Day Year                           | 3. Time of Death                            |
|                            | /Medic   | al               | Vorothy  | 1  | mings                                      |  |  | Dec. 12,                             | 2005                               | 8:05A M                                     |
|                            | Examin   | er               | 4a. Facility Name (If not institution, g                               |  |  | City, Town, or Loc                       | cation of Death                          |                                      | 4c. County of Death                |   |
|                            |  |                  | Civista Medica: 5. Social Security Number 6.                           | Sex 7. Age (In yrs.  |  | La Plata<br>Inderiyear If                | Under 24 Hrs.   8                        | . Date of Birth                      | Charles                            | lane (Chata as Faurice                      |
|                            | Funeral<br>Director  |                  | 238-54-6986  | 1□ M 21× 7.2   | Mo   |  | lours Min.                               | Month, Day, Yea                      | Cour                               | (1)   |
|                            |  |                  | Usual Residence of Decedent  | 164  | ,  |  |  | 1-6-143                              | 3 Dany                             | ille, VH                                    |
|                            | yland  |                  | 10a. State 10b. County   | 10c. Ci  | ty, Town or Location                       | 1  |  |                                      | 1                                  | 10d. Inside City Limits                     |
|                            | B Mai  | ctor             | Maryland Char  | les Po   | ort 70                                     | bacco                                    | }  |                                      |                                    | 1 X Yes 2 ☐ No                              |
|                            | or 28  | Oire             | 10e. Street and Number   |  |  | f. Zip Code                              |  | 10g. (                               | Citizen of What Cour               | ntry?                                       |
|                            | ath w  | Funeral Director | 6260 Brimps  | sfield Place   |  | 20677                                    | }  |                                      | ISA                                |   |
| (/)                        | er de  | une              | 11. Marital Status   | 12. Was Decedent Ever in U<br>Armed Forces?                    | J.S. 13. Was I<br>If Yes                   | Decedent of Hispar<br>, specify Cuban, M | nic Origin? (Speci<br>lexican, Puerto Ri | fy Yes or No-<br>can, etc.)          | 14. Race - Americ<br>Black, White, |   |
| 38                         | rs aft   |                  | 1 Never Married 2 Married  3 Widowed 4 Divorced                        | 1 ☐ Yes 2 XNo<br>If Yes, Give<br>Year or Dates:                | 1 🗆 Y                                      | es 25 No S                               | pecify:                                  |                                      | Specify:                           | V   |
| mming                      | within 72 hours after death with the Maryland<br>ene.<br>then "neturel", or Items 23s or 28s-1 show<br>is Modice Exercities reast be notified. | Completed by     | 15. Decedent's   |  | 16a. Decedent's                            | Usual Occupation                         | 1  | 16b.                                 | Kind of Business/In-               | dustry                                      |
| m m 21215                  | nin 72   | piet             | (Specify only highest of Elementary/Secondary (0-12)                   |  | (Give kind<br>life. DO N                   | of work done durin<br>OT use retired)    | ig most of working                       | 1                                    | 4                                  |   |
| 212                        | d with   | E O              | 12   | (1-401 34)   | Registe                                    | ered Nu                                  | irse                                     | /-                                   | lealth                             |   |
|                            | be filed<br>Ital Hygid<br>od other<br>event, I   | Be               | 17. Father's Name (First, Middle, La.                                  | st)  | 7  |  | Mother's Name (                          | First, Middle, Maid                  | en Sumame)                         |   |
| aryland                    | should bind Menti  | 2                | Giles Richi  | mond   |  |  | Matoas                                   | ie J                                 | hoson                              |   |
| a la                       | 2 sho<br>and<br>Is ma  | 1. 8             | 19a. Informant's Name/Relationship                                     | (Type, Print)  | 19b. Mailing Ad                            | dress (Street and i                      | Number or Rural I                        | Route Number, City                   | y or Town, State, Zip              | Code)                                       |
| X %                        | 5 ₹ 2 5  |                  | Felix Lummin   | 45 / SON   | 6260                                       | Brimps                                   | field M.                                 | , fort lo                            | bacco, Mo                          | 1.20677                                     |
| Dorok<br>Baltimore,        | Pages 1<br>nent of H<br>int: If iter   |                  | 20a. Method of Disposition  1 Burial 2 Cremation 3                     | Removal from State   | Place of Disposition<br>cemetery, cremator | y or other place)                        | Dat                                      | 9 20c.                               | Location - City or To              | wn, State                                   |
| tim (                      | t. Partmen   |                  | `4 □Donation 5 □ Other (Spec   | 110  | sedale (                                   | ometer                                   |  | 1-05 0                               | ange, New                          | wilersey                                    |
| (→ Bal                     | permit.<br>Departr<br>Imports<br>any Mi  |                  | 21. Signature of Foreral Service Lic                                   | ensee  | ~  | ne and Address of                        |  | 41                                   | 7 W. 150be                         |   |
|                            |  |                  | 23a. Part1. Enter the disease, or co                                   | ations that caused the deal                                    | th. Do not enter the                       |  |  | 1 Home S                             | chisbury 1                         | Approximate                                 |
|                            |  |                  | shock, or hear bilure. List on<br>Immediate Cause (Final               | ly one cause on each line.                                     |  |  | C 1                                      | A.                                   | •                                  | Interval Between<br>Onset and Death         |
|                            | Physician<br>/Medical  |                  | disease or condition<br>resulting in death)                            |  | membe                                      | anous                                    | Coli                                     | lis                                  |                                    |   |
|                            | Examiner   |                  |  | Due to (or as a consec   | quence ot):                                |  |  |                                      |                                    |   |
|                            |  | ē                | Sequentially list conditions, if any, leading to immediate             | b. Due to (or as a consec                                      | quence of):                                |  |  |                                      |                                    |   |
|                            | icate be executed<br>physician and<br>s the burial-transit   | Examiner         | cause. Enter Underlying Cause (Disease or injury that initiated events | C  |  |  |  |                                      |                                    |   |
| o,                         | an an<br>rial-tr   | Exe              | resulting in death) Last   | Due to (or as a consec   | quence of):                                |  |  |                                      |                                    |   |
| 68760,                     | icate be executed<br>physician and<br>s the burial-transit   | edical           |  | d  |  |  |  |                                      |                                    |   |
| -                          |  | Med              | IF FEMALE:   |  |  |  |  |                                      |                                    |   |
| Вох                        | The law requires that the death certific<br>ate has been signed by the atlending p<br>bage 2 should be detached for use as i                   | Physician/Me     | 23b. Was decedent pregnant in the past 12 months?                      | 23c. If yes, outcome of pregnative birth 2 ☐ Feta              | al death 3 □Ecto                           | pic pregnancy                            |  |                                      | 23d. Date of delive<br>Month       | ery<br>Day Year                             |
| 0                          | the a  | sici             | 1 Yes 2 No   | 4□Pregnant at time of o  | death 5 Othe                               | er (specify)                             |  |                                      | WORT                               | Day   |
| ď.                         | res that the de<br>signed by the a<br>be detached f  |                  | Part II. Other significant conditions                                  | contributing to death but not res                              | sulting in the underk                      | ing cause given in                       | Part I                                   | 23a Did tohacci                      | use contribute to th               | ne cause of death?                          |
| ds,                        | signe<br>d be  | d by             |  |  |  | ang occoor given in                      | T GICT.                                  |                                      |                                    | abiy 4 Unknown                              |
| Š                          | w require<br>been si<br>should l   | Completed        |  |  |  |  |  |                                      |                                    |   |
| Rec                        | has<br>ge 2  | m                |  |  |  |  |  | 24a. Was an<br>autopsy<br>performed? | prior to cor<br>death?             | psy findings available mpletion of cause of |
| <u>a</u>                   | sicien: The law<br>s certificate has t<br>lirector, page 2 s   | ပိ               | 25. Was case referred to medical                                       |  |  |  |  | 1 Yes 2 🗶                            | lo 1 ☐ Yes                         | 2 No  |
| Division of Vital Records, | ding Physicien: The I<br>h.<br>After this certificate ha<br>funeral director, page   | o Be             | examiner?  | Hospital:  | ER/Outpatient 3                            |  | Place of Death (                         |                                      | 6 ☐Other (Specify                  |   |
| of                         | g Phy<br>or this<br>oral d   | -                | 27. Manner of Death  | 28a. Date of Injury  | 28b. Time of                               | 28c. Injury at Work?                     |  | d. Describe how in                   |                                    | "   |
| <u>io</u>                  | Attending<br>r death.<br>ector: After  | atio             | 1 Natural 5 Pending 2 Accident investigati                             | (Month, Day Year)  | Injury<br>N                                |  | 2 🗆 No                                   |                                      |                                    |   |
| Vis                        | Attendi<br>er death.<br>ector: A<br>by the fu  | tific            | 3 ☐ Suicide 6 ☐ Could not determine                                    | 28e. Place of Injury - At h<br>building, etc. (Specia          | ome, farm, street, fa                      | actory, office                           | 28                                       | Location (Street City or Town, Sta   | and Number or Rura                 | l Route Number,                             |
| ā                          | tal or   | Certification:   |  | Dulluling, atc. (Special                                       |  |  |  | Only of Town, Sta                    | 116/                               |   |
|                            | ospil<br>hour<br>uner  |                  | 29a. Certifier 1 Certifying I  | Physicien: To the best of my known in the basis of examination | owledge, death occu                        | urred at the time, d                     | late and place, and                      | due to the cause                     | (s) and manner as st               | ated.                                       |
|                            | To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the                                     | Medical          | one)   | and manner stated.   | and and or investig                        |  |  |                                      |                                    |   |
|                            | To To To To To To To To To To To To To T   | 2                | 29b. Signature and tyle of certifier                                   | Mathe ma   | 3  | 29c. License nur                         |  | 29d. D                               | ate signed (Month, I               |   |
|                            | 3  | *                | Nam  | · (mm mc   |  | D 52                                     | 1287                                     |                                      | 12/12/2                            | 2007  |
|                            | 00   |                  | 30. Name and address of person wh                                      |  |  |  |  |                                      |                                    |   |
|                            | 10   |                  | Nalin Mathur, MD,  | 10 St. Patrick   |  | Ste. 404                                 | 4, Waldon                                | rf, Maryl                            | and 20603                          |   |
|                            | Sta<br>Registr   | _                | 200,000 40   | 2005   | H 1  | V s                                      |  |                                      |                                    |   |

05~8484 B.K.S Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend/ Unpend item#1.23a.27.28a-f.pen#E.(351.1/23/06 TT State of Maryland / Department of Health and Mental Hygiene ALBERTA MAE CAMERON Reg. No. UU5 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death DEC. Day **Physician** 16, 2005 0004  $A^{M}$ Albertha Mae Cameron /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner UNION HOSPITAL ELKTON CECIL If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2√2 F 213-96-3108 38 Yrs. Director August 8, 1967 MD Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits ehow ir then "naturel", or items 23a or 28a-f eho Tre Medical Examiner must be notified at 1 ☐ Yes 2 🛣 No Director MD Cecil E1kton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21921 205 West Pulaski Hwy. U.S.A. within 72 hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: þ Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Pages 1 and 2 should be filed within ment of Heelth and Mental Hygiene. ent: if Item 27 Is marked other then ' ury or other traumatic event, the Ms College (1-4or 5+) Elementary/Secondary (0-12) Housewife Household 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Herbert Hitchcock Brownie Thomas 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 205 W. Pulaski Hwy., James Cameron, III/husband Elkton, MD Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State December 23, permit. Page Department of Importent: if any Injury or once. 4 □ Donation 5 □ Other (Specify) Elkton Cemetery Elkton, MD 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Andrew G. Gee Funeral Home 259 E. Main St., Elkton, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Betw Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Cocaine and alcohol intexication /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) and Il-transit The law requires that the death certificate be executed Due to (or as a consequence of): the attending physicien a hed for use as the burial-Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant all time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 5 Other (specify) P.0. detached 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Š pe 3 Probably 4 Unknown page 2 should 1 Yes 2 No Completed 24b. Were autopsy findings available prior to completion of cause of death?

Yes 2□ No 24a. Was an hes autopsy performed? After this certificete 1D Yes 2 No or Attending Physicien: funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death / Check only one Hospital: 1 ☐ Inpatient 2 ▼ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 X Yes 2 No 28a. Date of Injury Fnd 28b. Time of Fnd 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred unk Certification; 1 Natural 5 Pending death. 12/15/05 11:31 P 1 ☐ Yes XX No investigation 2 Accident filled in by the within 24 hours efter deat To the Funeral Director: Could not be determined 3 Suicide 28l. Location (Street and Number of Rural Route Number, City or Town, State) 200 W. Pulaski Hwy. Place of Injury - At home, larm, street, factory, office building, etc. (Specify) 4 | Homicide found at home Rm. 12, Elkton, MD Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

27 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed (Month, Day, Year) DEC 2 8 2005

Tasha

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Jasha



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O.C.M.E

16, 2005

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Registrar

DEC 1 3 2005

|              |  |                     | . FOR  | partment of Health and Meartificate of Death  |                                  | ene<br>005 41917  |
|--------------|--|---------------------|--|---|----------------------------------|---|
|              |  |                     | Decedent's Name (First, Middle, Last)  |   | 2. Date of Death                 | 3. Time of Death  |
|              | Physicia<br>/Medic   |                     | Elnora Madonna Carrino   |   | Month<br>Decembe                 | er 10, 2005 1:35 P M  |
|              | Examin   |                     | 4a. Fecility Name (If not institution, give street and number)   | 4b. City, Town, or Location of Death  |                                  | 4c. County of Death   |
|              |  |                     | Wilson Health Care Center  | Gaithersburg  (i) If Under 1 Year   If Under 24 Hrs.  | O Data of Right                  | Montgomery  |
|              | Funeral<br>Director  |                     | 5. Social Security Number  108-32-5785  6. Sex 1 M 2 M F 7. Age (In yrs. last birthday) 108-32-5785  | Months Days Hours Min.  | 8. Date of Birth<br>(Month, Day, | Yeer) 9. Birthplace (State or Foreign Country) South Dakota |
|              |  |                     | Usual Residence of Decedent  |   | Julie 25                         |   |
|              | how  | _                   | 10a. State 10b. County 10c. City, Town or  | cocation  |                                  | 10d. Inside City Limits 1 ☐ Yes 2 ☐ No                      |
|              | 8a-f s   | cto                 | Maryland Montgomery Gaithers   |   |                                  |   |
|              | with ti  | Ē                   | 10e. Street and Number   | 10f. Zip Code<br>20877  |                                  | og. Citizen of What Country?                                |
|              | ns 23  | era                 | 301 Russell Avenue  11. Marital Status   | . Was Decedent of Hispanic Origin? (Spec<br>If Yes, specify Cuban, Mexican, Puerto F          |                                  | nited States  14. Race - American Indian,                   |
| ယ္           | filed within 72 hours after death with the Maryland<br>Hygiene.<br>Hyerthan "natural", or Items 23s or 28s-f show<br>http://www.instruct.com/iteds/show  | by Funeral Director | 1 Never Married 2 Married 1 ☐ Yes 2 No   | If Yes, specify Cuban, Mexican, Puerto F  1 ☐ Yes 2 ☑ No Specify:                             | lican, etc.)                     | Black, White, etc.  |
| 21215-0036   | ours aral', c  |                     | 3 ☑ Widowed 4 □ Divorced If Yes, Give Year or Dates:   | TEL TES ZEE NO Specify.   |                                  | Specify: White  |
| 5-           | natu   | Completed           | (Specify only highest grade completed) (Giv  | edent's Usual Occupation<br>re kind of work done during most of workin<br>DO NOT use retired) | g 1                              | 6b. Kind of Business/Industry                               |
| 12           | withly<br>ene.<br>than   | dmo                 | Elementary/Secondary (0-12) College (1-4or 5+)   | cher  |                                  | Education   |
| d 2          | filed<br>Hygi<br>other<br>ent, I   | Be Co               | 17. Father's Name (First, Middle, Last)  | 18. Mother's Name   | (First, Middle, N                | faiden Sumame)  |
| ılan         | uld be<br>Aenta<br>rked<br>tic ev  | To B                | Russell Jonathan Drafahl   | Edna Fr   | rench                            |   |
| Maryland     | permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Merial Hygiene. Important: if Item 27 is marked other than "natural; or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examinat must be retified at any injury or other traumatic event, the Medical Examinat must be retified at any one. |                     |  | ling Address (Street and Number or Rural 45th Street, N.W.,                                   |                                  |   |
| re,          | s 1 and 1 Heal   |                     | 20a. Method of Disposition 20b. Place of Dis   | position (Name of December place)   | er 12,                           | 20c. Location - City or Town, State                         |
| Baltimore,   | Page<br>nent c   |                     | 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Metror  '4 ☐ Donation 5 ☐ Other (Specify) Cremat   | OTILAN  |                                  | lexandria, Virginia   |
| Salt         | epartr<br>pportr<br>ny inj   |                     |  | 22. Name and Address of Facility DeVo   |                                  |   |
| _            | E 5 2 0 5  |                     |  |   |                                  | ithersburg, MD 20877  Approximate                           |
|              |  |                     | 23a. Part 1 Englithe disease, or complications that caused the death. Do not e shock of heart failure. List only one cause on each line.   | mer the mode of dying, such as cardiac of   | respiratory arre                 | Interval Between<br>Onset and Death                         |
|              | Pnysician<br>/Medical  |                     | disease or condition resulting in death)  Due to (or as a consequence of):   | 1) dementa  |                                  | 7 year  |
|              | Examiner   |                     |  |   |                                  |   |
|              | D =  | ner                 | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying   |   |                                  | ,   |
|              | ecute<br>and<br>-trans   | Examine             | Causa (Disease or lifting that initiated events resulting in death) Last Due to (or as a consequence of):  |   |                                  |   |
| 8760,        | cate be executed<br>physician and<br>the burial-transit  |                     | Due to (or as a consoquence or).   |   |                                  |   |
| 687          | ficate<br>physis the   | edicai              | d  |   |                                  |   |
| Вох          | death certifica<br>e attending ph<br>id for use as t   | n/M                 | IF FEMALE: 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death   | □Ectopic pregnancy  |                                  | 23d. Date of delivery                                       |
|              | 0 0 2  | Physician/Me        | in the past 12 months?  1 Yes 2 No  4 Pregnant at time of death  | Other (specify)   |                                  | Month Day Year  |
| P.O.         | that the de<br>ed by the<br>detached   | Phys                | 9 L Unknown  | and the same in Boat  | 220 Did tob                      | acco use contribute to the cause of death?                  |
| Ś            | es<br>pe   | by                  | Part II. Other significant conditions contributing to death but not resulting in the   | underlying cause given in Part I.   | 1 □ Ye                           |   |
| Sor          | w requir<br>been si<br>should  | etec                | The state of the s |   | 24a. Was ar                      | 24b. Were autopsy findings available                        |
| Vital Record | e la<br>has  | Completed           | deculity when  |   | autopsy                          | y prior to completion of cause of death?                    |
| tal          | Ician: Th<br>certificate<br>ector, pag   | O                   | 25. Was case referred to medical   | 26. Place of Death  | -1                               | 1 Yes 2 No  |
| 2            | S S  | To B                | examiner?  1  Yes 2 No   |   |                                  | nce 6 Other (Specify)                                       |
| n of         | ding Ph<br>th.<br>After th<br>funeral  |                     | 27. Manner of Death  11√⊒1√atural 5 □ Pending  28a. Date of Injury (Month, Day Year)  28b. Time Injury   | Work?   | 8d. Describe ho                  | w injury occurred   |
| sio          | Attending or death. ector: Atterby the fune  | cati                | 2 Accident investigation   | M 1 Yes 2 No  | mt Lanatina (Ot-                 | reat and Alumbar or Gum I Pauta Alumbar                     |
| Division     | after death<br>after death<br>Director: /  | Certification:      | 3 Suicide 4 Homicide  4 Homicide  4 Homicide  4 Homicide  4 Homicide  4 Homicide  4 Homicide  4 Homicide  4 Homicide  4 Homicide  4 Homicide   | street, factory, office   | City or Town                     | reet and Number or Rural Route Number,<br>, State)          |
|              | To the Hospital or Attendi<br>within 24 hours after death.<br>To the Funeral Director: A<br>completely filled in by the fu   |                     | 29a. Certifier (Check only (Check only 2) Medical Exeminer: On the basis of examination and/or   |   |                                  |   |
|              | To the H<br>within 24<br>To the Fi   | Medical             | one) and manner stated.  | 29c. License number   |                                  | Pd. Date signed (Month, Dey, Year)                          |
| 1            |  |                     | 29b. Signature and title of certifier  | DICICU  |                                  |   |
|              | 10   |                     | 30, Name and address of person who completed cause of death (Item 23a) (Typ  | e. Print)   |                                  | Je celviner 10, 700)  |
|              |  |                     | John R. Melnich 911 Mil  | all Are. Gail   | Pursa                            | December 10, 2005<br>Md 20879                               |
|              | Sta  | ite                 | 31. Date filed (Month, Day, Year) 32. Registrar's Signature  | arte .  | 0                                | , ,   |
| F            | Regist   | rar                 | DEC 13 2005  |   |                                  |   |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Reg. No. U U 5 Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year Physician 1808 Russell Donald Cole, Sr. 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Union Memorial Hospital Baltimore City Baltimore If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Nov. 20, 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign
Country) **Funeral** Year 1 X M 2 □ F Yrs. 577-44-5912 1934 Virginia Director Usual Residence of Decedent with the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: if item 27 is marked other then "natural", or items 23a or 28a-f ehow any injury or other traumatic event, the Madical Examinational Lie notified at once. 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 Yes 2 No Director White Plains Maryland Charles 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 10832 Willetts Crossing Road 20695 US Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2X No White Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Residential Home Bldr. Foreman 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Shelby Cole Charity Bolt 19a. Informant's Name/Retationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10832 Willets Crossing Road, White Plains, MD 20695 Dorothy E. Cole - Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State 4 □Donation 5 □ Other (Specify) Middleburg Memorial Cem Middleburg, Virginia 21. Signature of Funeral Service Licensee 22. Name and Address of Facility M00053 3035 Old Washington Rd. POB 156, Waldorf, MD 20604 Huntt Funeral Home 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final lea torial **Physician** erurat 5 MM disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner 30 Min Drain Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of). attending physician a for use as the burial-Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Day 4☐Pregnant at time of death 5 Other (specify) signed by the a 1 ☐ Yes 2 ☐ No 9☐ Unknown 9 Unknown Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 Tes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an cate has page 2 s autopsy performed? res 2 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one)

Be ို Certification:

Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) npatient 2 ER/Outpatient 3 DOA

5 Pending investigation

and manner stated

28b. Time of

28c. Injury at Work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier

6 Could not be

determined

1 ☐ Yes 2 XNo

27. Manner of Death

1 Accident

3 Suicide

29a. Certifier

4 Homicide

29d. Date signed (Month, Dey, Year)

person who completed gause of death (Item 23a) (Type, Print) 30. Name and address of N.MC

M. 9 Union

Director: After th

within 24 hours a To the Funeral C

Medical

State Registrar

Baltimore, Maryland 21215-0036

| an  | 1 - State<br>Registrar 1. Decedent's Name (First, Midd  | fle, Last)   |  |  | Cen  | tificate o  | of Dea   | th   | 2. Date of D   | Reg. No<br>eath Da   | UU   | 5<br>Year  | 3. Time of Death   |
|---|---|--|--|--|--|---|--|--|--|--|--|--|--|
| an<br>al  | Maria E. Clo  | cker   |  |  |  |   |  |  | Decemb   | œr 8   | 3, 20  | 05   | 9:30 P   |
| er  | 4a. Facility Name (If not institutio  | -  | nu <i>mber)</i>  |  |  | 4b. City, Tow   |  | on of Death  |  | 40   | . County of  |  |  |
|   | 8277 WB&A Road 5. Social Security Number  | 6. Sex   | 7 Ann //   | 'n yrs. last bir   | rth day)   | Seven   |  | der 24 Hrs.  | 8. Date of Bi  |  | Anne   |  |  |
|   | 214–44–4615 Usual Residence of Decedent   | 1 □ M 2 🔀 F  |  |  | Yrs.   | Months Da   |  |  | 4-22-1   | ay, Year,  | ' I  | Coun   | lace (State or Fore<br>try)<br>yland   |
|   | 10a. State 10b. County  | 4  | 10   | 0c. City, Tow  | m or Loc   | ation   |  |  |  |  |  | 1  | 0d. Inside City Lin  |
| cto   | Maryland Anne   | Arundel  |  | 5  | Seve:  | rn  |  |  |  |  |  |  | 1☐Yes 2☐X  |
| Director  | 10e. Street and Number  |  |  |  |  | 10f. Zip Cod  | 9  |  |  | 10g. Ci  | tizen of Wh  | at Coun  | itry?  |
| Funeral   | 8277 WB&A Roa   |  |  |  |  | 2114  |  |  |  |  | USA  |  |  |
| nu  | 11. Marital Status  | Armed  | ecedent Eve<br>Forces?   | er in U.S.   | 13. W  | las Decedent (<br>Yes, specify C  | of Hispanic<br>Juban, Mex  | Origin? (Sp<br>ican, Puerto                        | ecify Yes or N<br>Rican, etc.)   | 0-   | 14. Race -<br>Black,   | - Americ<br>White,   |  |
| þ   | 1 □ Never Married 2 ☑ Mar<br>3 □ Widowed 4 □ Divorced   | Year or  | s 2 XNo<br>Give X<br>r Dates:  |  | 12   | ¥ Yes 2□I   | No Spec  | city:  |  |  | Specify:   | Wh   | ite  |
| ete   | 15. Deceder<br>(Specify only highe  | nt's Education<br>est grade complete   | d)   | 16a.   | (Give k  | ent's Usual Oc<br>and of work do<br>O NOT use re  | ne during n  | nost of work                                       | ıng  | 16b. K   | and of Busi  | iness/Inc  | dustry   |
| Completed   | Elementary/Secondary (0-12)   | College  | (1-4or 5+)   |  |  | lth & E   | ,  | , λid  |  | ,  | Food S   | Stor   | _  |
| Ð   | 12th<br>17. Father's Name (First, Middle,   | , Last)  |  |  | iica.  | ICII & I  |  |  | e (First, Middle   |  |  |  | <u> </u>   |
| 0   | Gerardo   | Perez  |  |  |  |   |  | Chris  | tina   | Во   | orwick   | ζ.   |  |
| -   | 19a. Informant's Name/Relations   |  |  |  |  |   |  |  | al Route Numb  |  |  |  | Code)  |
|   | Ronald A. Clock   | er/ Husba  | and  | 8  | 3277   | WB&A F  | Road,  | Sever  | n, Mary  | land   | 2114   | 44   |  |
|   | 20a. Method of Disposition<br>11☑ Burial 2 ☐ Cremation  | 3 Removal from   | 1  |  |  | ition (Name of<br>atory or other  |  |  | Date   | 20c. L   | ocation - Ci   | ity or To  | wn, State  |
|   | 4 Donation 5 ☐ Other (5   | Specify)   |  | Lakevi   |  | Mem'l.  |  | 1  |  |  | kesvi]   |  |  |
|   | 21. Signature of Funeral Service  | Ligensee   |  |  |  |   |  |  |  |  |  |  | al Home<br>D 21037   |
|   | disease or condition  |  | rdiac  | arryt  | hmia   | ,   |  |  |  |  |  |  |  |
|   | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that intiated events resulting in death) Last   | b. Due to  | to (or as a co<br>ocard  | arryt  | of):<br>farc   |   |  |  |  |  |  |  | Interval Between<br>Onset and Death  |
|   | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events   | b. Due to d  | to (or as a co   | onsequence onsequence or or or or or or or or or or or or or   | of): farc  |   |  |  |  |  | 23d. Date o  |  | Onset and Death  |
| by Physician/Medical                                | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that intitated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 \( \text{Yes} \) 2 (\text{Ye} \) No  | b. Due to d.  23c. If yes, c. 1   Live 4   Pre 9   Unit  | to (or as a co   | onsequence onsequence or onseq | of): farc  | etion  Ectopic pregna Other (specify,   |  | ut I.  |  | tobacco  | Month  | ute to the   | onset and Death  ry Day Year e cause of death?   |
| Completed by Physician/Medical Examiner             | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that intiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown  Part II. Other significant conditi                                  | b. Due to the total property of the total pr | to (or as a co   | onsequence onsequence or onseq | of): farc  | etion  Ectopic pregna Other (specify,   |  | urt I.   | 1 🗆<br>24a. Was  | Yes 2  | Month use contribu   | ute to the   | ry Day Year e cause of death? ably 4   |
| Be Completed by Physician/Medical                   | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No 9 Unknown  Part II. Other significant conditions are in the past 12 months? | b. Due to My Due to Due | to (or as a co   | onsequence of the consequence of | of): farc of):  3   E 5   0  | Ectopic pregna<br>Other (specify,<br>derlying cause   | given in Pa  | ace of Death                                       | 24a. Was auto perfic   | Yes 2 is an psy primed? 2 No   | Month use contribu  No 3  24b. We pric dea 1   | Proba  | Onset and Death  Ty Day Year  e cause of death?  ably 4 © Inkno  by findings availant of cause of cause of cause of death?   |
| o Be Completed by Physician/Medical                 | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  | Due to My Due to | to (or as a co   | onsequence of the consequence of | of):  farc of):  3   E 5   0   | Ectopic pregna Other (specify, derlying cause   | given in Pa  | ace of Death                                       | 24a. Was auto performe S Resi  | Yes 2 i an pry pry promed? 2 No one idence   | Month use contribu  No 3  24b. We price dea 1  6 Other   | ute to the Proba   | Onset and Death  Ty Day Year  e cause of death?  ably 4 onknoton on the cause of th |
| o be completed by Physician/Medical                 | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  | Due to My Due to My Due to Due to My Due to  | to (or as a co   | onsequence of the consequence of | of): farc of):  3   E 5   0  | Ectopic pregna Other (specify, derlying cause   | given in Pa  | ace of Death                                       | 24a. Was auto perfic   | Yes 2 i an pry pry promed? 2 No one idence   | Month use contribu  No 3  24b. We price dea 1  6 Other   | ute to the Proba   | Onset and Death  Onset and Death  Onset and Death  Onset and Death  Onset and Death  Onset and Death  Onset and Death  Onset and Death  Onset and Death  Onset and Death   |
| to be Completed by Physician/Medical                | Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  | Due to My Due to My Due to My Due to  | to (or as a coordinate of the  | onsequence of all inconsequence of onsequence of onsequence of onsequence of onsequence of death of resulting in the of death of resulting in the office of onsequence of  | of):  farc of):  3   E 5   0  utpatient Time of njury                          | Ectopic pregna Other (specify, derlying cause   | 26. Pt Other: 4  | ace of Death                                       | 24a. Was auto perfu 1 Yes n Check only o   | tobacco v<br>Yes 2<br>san<br>psy<br>pormed?<br>22 No<br>one<br>idence<br>how injure                  | Month use contribution of Month  24b. We price dea 1 [ 6 ] Other ry occurred od Number   | ute to the Proba   | Onset and Death  Onset and Death  Day Year  e cause of death  ably 4 Dunknow  osy findings availance in pletion of cause  2 No   |
| Certification: To Be Completed by Physician/Medical | Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  | Due to My b. Due to My b. Due to d.  | to (or as a coordinate of the  | onsequence of all inconsequence  of):  farc of):  3   E 5   0  in the unc  utpatient Time of niury  irm, street | Ectopic pregna Other (specify, derlying cause   | 26. Pt  Other: 4  I) ury at Vork?  Yes 2                                 | ace of Death                                       | 24a. Was auto perfu 1 Yes 1 Check only of Check only of Check only of City or To | Yes 2 an psy ormed? 22 No one) idence how injure   | Month use contribution 3 24b. We price dec 1 6 Other ry occurred and Number (s)  | ute to the Probable autoport a | onset and Death  ry Day Year  e cause of death? ably 4 ©onknot  explication of cause 2 No  Route Number,   |
| To Be Completed by Physician/Medical                | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  | Due to Myy b. Due to C. Due to d. Du | to (or as a coordinate of the  | onsequence of all inconsequence  of):  farc of):  3   E 5   0  in the unc  utpatient Time of niury  irm, street | Ectopic pregna Other (specify, derlying cause  3 DOA 28c. Ir M 1 et, factory, office occurred at the astigation, in m         | 26. Pt  Other: 4  I) ury at Vork?  Yes 2                                 | ace of Death Nursing Ho                            | 24a. Was auto perfu 1 Yes 1 Check only of Check only of Check only of City or To | Yes 2 is an psy promed? 2 No one) idence how injute Street anwn, State cause(s) date and             | Month use contribution 3 24b. We price dec 1 6 Other ry occurred and Number (s)  | ute to the Probate autoporto constith?    Yes   (Specify,   or Rural at the probate as standard at the | onset and Death  Try Day Year  e cause of death? ably 4 ©onknot  by findings availa poletion of cause  2 No  Route Number,  ated. the cause(s)   |
| Certification: To Be Completed by Physician/Medical | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  | Due to Myy b. Due to C. Due to d. Du | to (or as a coordinate of the  | onsequence of all inconsequence  of):  farc of):  3   E 5   0  in the unc  utpatient Time of niury  irm, street | Ectopic pregna Other (specify, derlying cause  3 DOA 28c. Ir M 1 et, factory, office occurred at the astigation, in m         | 26. Pt Other: 4     Jury at Vork?     Yes 2                              | ace of Death Nursing Ho                            | 24a. Was auto perfu 1 Yes 1 Check only of Check only of Check only of City or To | Yes 2 is an psy promed? 2 No one) idence how injute Street anwn, State cause(s) date and             | Month use contribution No 3 24b. We price dec 1 6 Other ry occurred and Number of price and number of pric | ute to the Probate autoporto constith?    Yes   (Specify,   or Rural at the probate as standard at the | onset and Death  ry Day Year  e cause of death ably 4 @Onkno by findings availa poletion of cause 2 No  Poute Number, ated. the cause(s)   |
| Certification: To Be Completed by Physician/Medical | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  | Due to Myy b   | to (or as a concentration of the concentration of t | onsequence of all inconsequence  of):  farc of):  3   E 5   0  Itpatient Time of niury Irm, stree               | Ectopic pregna Other (specify, derlying cause  3 DOA 28c. Ir M 1 et, factory, offic occurred at the stigation, in m 29c. Lice | 26. Pt  Other: 4  I) ury at  Vork?  Yes 2  ee a time, date y opinion, co | ace of Death Nursing Ho No and place, death occurr | 24a. Was auto perfu 1 Yes 1 Check only of Check only of Check only of City or To | Yes 2 is an psy ormed? 2 No one) idence how injute Street and www. State cause(s) date and 29d. Date | Month use contribution No 3 24b. We price dec 1 6 Other ry occurred and Number of price and number of pric | ute to the Probate autoporto constith?    Yes   (Specify,   or Rural at the probate as standard at the | onset and Death  ry Day Year  e cause of death ably 4 Inknows findings avail apletion of cause 2 No  Poute Number, ated. the cause(s)  |

|            |   | 1              | State of Maryland / Department of Healt  |  | al Hygiene                                 | 105 [                                       | 1920   |
|------------|---|----------------|--|--|--|---|--|
|            |   |                | State Registramend Item #23b Per Phy G850 92/28/419 off Deal. Decedent's Name (First, Middle, Last)  | L. D.                                    | ate of Death                               | Year  | 3. Time of Death                                   |
|            | Physicia<br>/Medic  | al .           | Hazel Marie Collins  | De                                       | ec. 7,                                     |   | 6:00 p <sup>M</sup>                                |
|            | Examin  |                | Anne Arundel Medical Center  4b. City, Town, or Local Anne Arundel Medical Center  | tion of Death                            |  | County of Death                             | undel  |
|            | Formul  |                | Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Ur   | nder 24 Hrs.   8. Di                     | ate of Birth                               | 9. Birtho                                   | lace (State or Foreign                             |
|            | Funeral<br>Director   |                | 215-20-5273 1 Months Days Hot  |  | n. 6, 192                                  | 23 Coun                                     | MD   |
|            | pug *   | -              | Usual Residence of Decedent  |  |  | 1   | 0d. Inside City Limits                             |
|            | Maryli<br>f sho   | .              | MD Anne Arundel Arnold   | đ  |  |   | 1 ☐ Yes 2 🙀 No                                     |
|            | n the   | Director       | 10e. Street and Number 10f. Zip Code   |  | 10g. Citiz                                 | en of What Coun                             | ntry?  |
|            | 238 c   | la             | 809 Windsor Road 21012   |  |  | USA   | an Indian  |
| 36         | be filed within 72 hours after death with the Maryland tal Hygiene. ad other than "natural", or Itams 23a or 28a-f show event, Ina Madical Examiner must be notified at | by Funeral     | 11. Marital Status  1 □ Never Married 2 □ Married  3 □ ★ Alidowed 4 □ Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 □ Yes 2 ☒ No If Yes, Give Year or Dates:  13. Was Decedent of Hispani If Yes, specify Cuban, Me  1 □ Yes 2 ☒ No Specific Armed Size Year or Dates:  |  | i, etc.)                                   | 4. Race - Americ<br>Black, White,  Specify: |  |
| 21215-0036 | 72 hou  |                | 15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during life. DO NOT use retired)  | most of working                          |  | nd of Business/Inc                          | dustry   |
| 121        | within<br>ene.<br>than "  | Completed      | Elementary/Secondary (0-12) College (1-4or 5+)   |  | A &  | cery Sto                                    | ore  |
| 0          | filed v<br>Hygie<br>other f   | e Co           |  | Mother's Name (Firs                      |  |   |  |
| ılan       | should be<br>nd Mental<br>marked o  | To Be          | George Margaroff Ma  | arie Frat                                | Z  |   |  |
| Maryland   | ges 1 and 2 should<br>it of Health and Men<br>if item 27 is marke<br>or other traumatic   | 7              | 19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and N   |  |  | Town, State, Zip                            | Code)  |
|            | ges 1 and<br>t of Health<br>If item 27<br>or other t  |                | Larry E. Collins/Son 809 Windsor Roa   | Dec. Date                                | 7  | cation - City or To                         | own, State   |
| MOL        | Pages<br>nent of<br>int: If it  | Ĭ              | 1 □ Burial 2 □ Cremation 3 □ Removal from State  1 □ Donation 5 □ Other (Specify)  Metro Crematory   | 200                                      |  | Ltimore,                                    | MD   |
| Baltimore, | permit. Pag<br>Department<br>Important: I<br>any injury o   |                | 21. Signature of Funeral Service Licensee  22. Name and Address of Barranoc & South State Service Licensee  495 Gov. rite  | ons. P.A.                                | Severna<br>Severna                         | Park Fu<br>Park, M                          | neral Home<br>D 21146                              |
|            |   |                | 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such shock, or heart failure. List only one cause on each line.   | ch as cardiac or res                     | piratory arrest,                           |   | Approximate<br>Interval Between<br>Onset and Death |
|            | Physician   | : 1            | Immediate Cause (Final disease or condition resulting in death)  | LES)                                     |  |   | 48 Mayor   |
|            | /Medical<br>Examiner  |                | tuato (or as a consequence of):  Hemorrha  Hemorrha  | agic Sho                                 | ck   |   |  |
|            | 100   | Je.            | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury  | agic bio                                 | CK   |   |  |
|            | icuted<br>nd<br>transit   | Examine        | that initiated events C.   |  |  |   |  |
| 8760,      | death certificate be executed<br>e attending physician and<br>of for use as the bunal-transit   | al Ex          | resulting in death) Last Due to (or as a consequence of):  |  |  |   |  |
| 687        | ificate<br>g phys<br>as the   | edical         | d.   |  |  | L I   |  |
| Box        | eath certific<br>attending pl<br>I for use as t   | Physician/Med  | IF FEMALE: 23b. Was decedent pregnant 1  |  | 2  | 23d. Date of delive                         | ery<br>Day Year                                    |
| .O. E      | ne dea<br>the at<br>hed fo  | ysici          | in the past 12 months?  1  |  |  |   | ,  |
| Ω.         | The law requires that the de<br>sie has been signed by the s<br>bage 2 should be detached i   |                | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in   | Part I.                                  | 23e. Did tobacco u                         | se contribute to t                          | he cause of death?                                 |
| rds        | w requires<br>been sign<br>should be  | ed by          |  |  | 1 Tes 2                                    | □No 3□Prob                                  | oably 4 Uknown                                     |
| Records,   | e law re<br>has bee<br>je 2 sho   | Completed      |  |  | 24a. Was an autopsy                        | prior to co                                 | opsy findings available impletion of cause of      |
| R          |   | Con            |  |  | performed?<br>1 ☐ Yes 2 No                 | death?                                      | 2 🗆 No   |
| Vital      | cer<br>rec  | o Be           | examiner? Others   | Place of Death (Ch                       |  | S ∏Other (Specia                            | fv)  |
| of         |   | n: To          | 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Model 28c. Injury at Mode |  | Describe how injur                         |   | 57   |
| sior       | Attending Ph<br>r death.<br>ector: Affer th<br>by the funeral   | catlo          | 2 Accident investigation M 1 Yes   |  | (0)  | 14/   | 10-11  |
| Division   | after d<br>Direct<br>In by  | Certification: | 3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | Location (Street an<br>City or Town, State |   | ai noule ivaliber,                                 |
|            | To the Hospital or Attens within 24 hours after death To the Funaral Director: completely filled in by the  | Medical C      | 29a. Certifier (Check only one)  1 Pertifying Physician: To the best of my knowledge, death occurred at the time, dr. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion and manner stated.   | ate and place, and on, death occurred at | due to the cause(s)                        | and manner as s<br>place, and due t         | stated.<br>o the cause(s)                          |
|            | To the<br>within<br>To the<br>comple  | Me             | 29b. Signature/she little of certified  DM3  | 5 4 9 Y                                  | 29d. Dat                                   | e signed (Month,                            | Day, Year)   |
|            |   |                | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)   | le K                                     | edul                                       | certes                                      |  |
|            | St<br>Regist  | ate<br>rar     | 31. Date filed (Month, Day, Year)  DEC 1 2 2005  32 Registrar's Signature  |  |  |   |  |
|            |   |                |  |  |  |   |  |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 05 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Year Laura H. Clise 12 13 2005 /Medical 10:35 AM 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner St. Vincent DePaul Nursing Center Frostburg,
If Under 24 Hrs. 8. MD All**e**gany If Under 1 Year **Funeral** 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1□ M 2×F Hours Months Davs Director 215-36-9784 10-May-1913 Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with tha Maryland 10a. State 10c. City. Town or Location item 27 is marked other than "natural", or items 23s or 28s-f show other traumatic event, the Medical Examinar must be notified at 10d. Inside City Limits Director 1 Yes 2 □ No Maryland Allegany Frostburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 54 Hawthome Drive Funeral 21532-U.S.A 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No <u>ک</u> Specify. 3 Widowed 4 □ Divorced Year or Dates White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 12 teacher education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Health and Mental Horace R. Hamilton Annie Clark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 328 Hamlet Circle Dona Dusman daughter Edgewater Maryland 21037 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Department of F important: If ite any injury or ott 20c. Location - City or Town, State 18 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Frostburg Memorial Park 16-Dec-2005 Frostburg Maryland 21 Signature of Funeral Survice Licenses 22. Name and Address of Facility Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532 Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician /Medical Immediate Ceuse (Final disease or condition resulting in deeth) 15 days Sepsis Examiner Physician/Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown þ Completed 24a. Was an autopsy 24b. Were autopsy findings available prior to completion of cause of death? T | Yes Z) NO 1 ☐ Yes 2 No æ 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 2 1 Yes 2 No 1 🗆 Inpatient 2 ER/Outpatient 3 DOA 4 Vursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28c. Injury at Work? 27. Menner of Death Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred

Attending Physician: The law requires that the death certificate be executed Box 68760, Division of Vital Records, P.O.

3altimore, Maryland 21215-0020

Medical Certification:

1 Natural 2 Accident

3 ☐ Suicide

29a. Certifier

4 \ Homicide

29b. Signature and title of certifier

filled in by the funeral after death. To the Hospital of within 24 hours at To the Funeral D complataly

nds

Registrar

State

31. Date filed (Month, Day, Year)



MD

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

29c. License number

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

1 ☐ Yes 2 ☐ No

1)0055325

Frestburg

29d. Date signed (Month, Day, Year)

Location (Street and Number or Rural Route Number, City or Town, State)

DEC 14, 2005

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print)

WONSOCK SHIN MD 48 Tarn Terrace

DEC 1 5 2005

5 Pending investigation

6 Could not be determined

wincock Shi



|  |                | For<br>State<br>Registrer  | State of Maryland   |                                 | artment of Hertificate of L                                    |  |  | jiene<br>1. 2. 0 0               | 5                                    | 41922                   |
|--|----------------|--|---|---------------------------------|--|--|--|----------------------------------|--------------------------------------|-------------------------|
|  |                | Decedent's Name (First, Middle, Last)  |   |                                 |  |  | 2. Date of Dea                         | th                               |                                      | 3. Time of Death        |
| Physicia<br>/Medica  |                | LIAN JENQ WON  | G CHOW  |                                 |  |  | Decembe                                | er 7 2                           | Year<br>005                          | 10:05A M                |
| Examine  |                | 4a. Facility Name (If not institution, give s  | treet and number)   |                                 | 4b. City, Town, or   | Location of Death                                  | h                                      | 4c. County                       | of Death                             |                         |
|  |                | 208 Park Avenue, A   | *   | - A bink to 1                   | Gaither  | sburg  | 0.5-1-75:4                             |                                  | gomer                                | <u> </u>                |
| Funeral<br>Director  |                | 5. Social Security Number 6. Sex 1 $\square$   | 7. Age (In yrs. I   | ast birthday)<br>Yrs.           | Months Days  | Hours Min.   | 8. Date of Birth<br>(Month, Day        | , Year)                          | Cour                                 |                         |
|  | -              | Usual Residence of Decedent  |   |                                 |  |  | July 1,                                | 1912                             | Chin                                 | a                       |
| nd Mental Hygiene.<br>makked other than "natural", or Items 23e or 28e-f show<br>imatic event, it a Madical Exertilier must be nulliavi at |                | 10a. State 10b. County   | 10c. City   | , Town or Lo                    | cation   |  |  |                                  | 1                                    | 10d. Inside City Limits |
| B-f s  | cto            | Maryland Montgome  | ry Ga:  | ithers                          | burg   |  |  |                                  |                                      | 1⊠Yes 2 No              |
| or 26  | Directo        | 10e. Street and Number   |   |                                 | 10f. Zip Code  |  | 1                                      | log. Citizen of                  | What Cour                            | ntry?                   |
| 8 23a  | a              | 208 Park Avenue, A   |   |                                 | 20877  |  |  | Hong K                           |                                      |                         |
|  | by Funeral     | 11. Marital Status  1 ☐ Never Married 2⊠ Married  3 ☐ Widowed 4 ☐ Divorced                                 | 2. Was Decedent Ever in U.<br>Armed Forces?<br>1 ☐ Yes 2 🕱 No<br>If Yes, Give<br>Year or Dates: | 1                               | Vas Decedent of His<br>f Yes, specify Cubar<br>I ☐ Yes 2፟፟፟ No | spanic Origin? (S<br>n, Mexican, Puert<br>Specify: | pecify Yes or No-<br>o Rican, etc.)    |                                  | ce - Americ<br>ck, White,<br>y: Asia |                         |
| ical i   | ted            | 15. Decedent's Educ  | eation (  | 16a. Deced                      | ient's Usual Occupa  | tion   | 4-1                                    | 16b. Kind of B                   | usiness/In                           | dustry                  |
| N N  | ompleted       | (Specify only highest grade<br>Elementary/Secondary (0-12)   | Completed) College (1-4or 5+)   | life. L                         | kind of work done d<br>DO NOT use retired)                     | uring most of wor                                  | rking                                  |                                  |                                      |                         |
| 9 1  | Con            | 0  |   | Нс                              | usewife  |  |  | Domes                            | tic                                  |                         |
| ven  | Be             | 17. Father's Name (First, Middle, Last)  |   |                                 |  |  | ne (First, Middle,                     |                                  | ne)                                  |                         |
| atic   | ၉              | Yin Ku Wong  |   |                                 |  |  | eng Won                                |                                  |                                      |                         |
| raun   |                | 19a. Informant's Name/Relationship (Type William Shui Cheng  |   |                                 | g Address (Street a  |  |  |                                  |                                      | •                       |
| ther   |                | 20a. Method of Disposition   |   |                                 | ark Avenu<br>sition (Name of                                   | e, #310,   |  | 20c. Location                    |                                      | land 20877              |
| واق  |                | 1 ☐ Burial 2 🖾 Cremation 3 ☐ R   | emoval from State   | emetery, cren                   | natory or other place<br>1n Cremat                             |  |  |                                  |                                      |                         |
| in a   |                | <ul><li>4 □ Donation 5 □ Other (Specify)</li><li>21. Signature of Funeral Service License</li></ul>        |   |                                 |  |  |  |                                  | Ju, FI                               | aryrand                 |
| any<br>onc   |                | ) A) A   | V to  | H                               | Name and Address   | DI FUNE  | RAL HOME                               | INC.                             | princ                                | , MD 20904              |
|  |                | 23a. Part1. Enter the disease, or complishock, or heart bill. List only on                                 | cations that caused the death   |                                 |  |  |  |                                  | brrn                                 | Approximate             |
| cian   |                | Immediate Causa (Final   |   |                                 |  |  |  |                                  |                                      | Onset and Death 3 Years |
| ical   |                | disease or condition resulting in death)   | Coronary Hea  Due to (or as a consequ   |                                 | ease   |  |  | -                                | -                                    | 3 lears                 |
| ner  | - 1            | Sequentially list conditions   |   |                                 |  |  |  |                                  |                                      |                         |
|  | ner            | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Disease or injury | Due to (or as a consequ   | ence of):                       |  |  |  |                                  |                                      |                         |
| וופ סחומי וופוסווים  | Examine        | that initiated events resulting in death) Last   | Due to (or as a consequ   | roppe of):                      |  |  |  |                                  |                                      |                         |
|  | caiE           |  | Due to (or as a consequ   | ierice or).                     |  |  |  |                                  |                                      |                         |
|  | ᇹ              | d  |   |                                 |  |  |  |                                  |                                      |                         |
| 150 93   | /Me            | IF FEMALE:   | 3c. If yes, outcome of pregna   | ncy                             |  |  |  | 23d Da                           | te of delive                         | arv                     |
| detached for use as  | Physician/Me   | 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No   | 1 Live birth 2 Fetal<br>4 Pregnant at time of de  | death 3                         | Ectopic pregnancy<br>Other (s <i>pecify)</i>                   |  |  |                                  | nth                                  | Day Year                |
| 2  | hys            | 9 Unknown  | 9□ Unknown  |                                 |  |  |  |                                  |                                      |                         |
| 190 0  | by P           | Part II. Other significant conditions con  |   | ilting in the ur                | nderlying cause give   | n in Part I.                                       | 23e. Did tol                           | bacco use cont                   | inbute to th                         | ne cause of death?      |
|  |                | Chronic Renal Fa   | ilure   |                                 |  |  | 1 🗀 Ye                                 | es 2⊠No                          | 3 Prob                               | ably 4 Unknown          |
| S SUC  | ompleted       | Cerebral Vascular  | Accident  |                                 |  |  | 24a. Was a                             |                                  |                                      | psy findings available  |
| Dag<br>B   | E O            |  |   |                                 |  |  | perform                                | med?                             | death?<br>1 □ Yes                    |                         |
| 50   | BeC            | 25. Was case referred to medical   |   |                                 |  | 26. Place of Dea                                   | ith (Check only on                     |                                  |                                      |                         |
| all dire   | 2              | 1 163 2 2 140  |   | ER/Outpatien                    | t 3 DOA Othe   | r: 4 🗍 Nursing H                                   | ome 5 🔀 Reside                         | ence 6 🗆 Oth                     | er (Specify                          | v)                      |
| funeral  |                | 27. Manner of Death 1   Natural 5 □ Pending  | 28a. Date of Injury<br>(Month, Day Year)  | 28b. Time of<br>Injury          | Work   | at<br>?  | 28d. Describe ho                       | ow injury occur.                 | red                                  |                         |
| the n  | cati           | 2 Accident investigation 3 Suicide 6 Could not be  |   |                                 |  | ′es 2□No   |  |                                  |                                      |                         |
| a u o  | Certification: | 4 Homicide determined  | 28e. Place of Injury - At ho building, etc. (Specify  | me, farm, str                   | eet, factory, office   |  | 28f. Location (St<br>City or Town      | treet and Numb<br>n, State)      | er or Rura                           | l Route Number,         |
| completely filled in by the fu   | edical C       | 29a. Certifier 1⊠ Certifying Phys<br>(Check only one) 2  Medicel Exemin                                    | ician: To the best of my knowner: On the basis of examinat and manner stated.                   | wledge, death<br>ion and/or inv | occurred at the time<br>restigation, in my op                  | e, date and place<br>inion, death occu             | , and due to the carred at the time, d | ause(s) and ma<br>ate and place, | and due to                           | ated.<br>the cause(s)   |
| completely filled  | Me             | 29b. Signature and title of certifier  |   |                                 | 29c. License   | number   | 2                                      | 9d. Date signe                   | d (Month,                            | Day, Year)              |
|  |                | DIA V  | ทูอ,  |                                 | D-005  | 2457   |  | Decembe                          | r 8,                                 | 2005                    |
|  |                | 30. Name and address of person who co.   |   |                                 |  |  |  |                                  |                                      |                         |
|  |                | Mo-Ping Chow, MD,  | 9001 Shady Gr   | cove C                          | ourt, Gai  | thersbur   | g, Marya                               | 1dn 208                          | 377                                  |                         |
| Stat   |                | 31. Date filed (Month, Day, Year)  | 32 Registrar's Signal   | ure de                          | ade  |  |  |                                  |                                      |                         |
| Registra   | 17             | DEG 12 /B  | III Manage de   | P 450                           |  |  |  |                                  |                                      |                         |

|              |  | 1                 | For State Registrar  |   | partment of Health and I   | Mental Hygien   | 11115 1.1073  |
|--------------|--|-------------------|--|---|--|---|---|
|              | Physici<br>/Medic  | an<br>al          | 1. Decedent's Name (First, Middle, Last)  Pauline Virgin  La. Facility Name (If not institution, give street as  |   | 4b. City, Town, or Location of Death   | 2. Date of Death Month December 1                             |   |
|              | Examin Funeral Director  | G!                | Garrett-County Memors. Social Security Number 6. Sex 1 M 2E  | 7. Age (In yrs. last birthday   | Ookland    If Under 1 Year   If Under 24 Hrs.   Months   Days   Hours   Min.                     |   | 9. Birthplace (State or Foreign Country) 924 Maryland                                   |
|              | he Maryland<br>8a-f show<br>ciffed at  | ector             | Usual Residence of Decedent  | 10c. City, Town or I  | Oakland  | 100.0   | 10d. Inside City Limits 1 ☐ Yes 2 反 No itizen of What Country?                          |
| 9            | nit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland arrenet of Health and Mental Hygiene. ortant: If item 27 is marked other then "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Exercit et must be notified at higher of the fire of | Funeral Director  | 1 Never Married 2 Married 1 □  |   | 10f. Zip Code  21550  Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert  |   | USA  14. Race - American Indian, Black, White, etc.  Specify: White                     |
| 21215-0036   | within 72 hours<br>nne.<br>Ithen "natural",<br>ia Medical Era  | Completed by      | 3 ★Widowed 4 Divorced Yes  15. Decedent's Education (Specify only highest grade comp  Elementary/Secondary (0-12) Col  | ar or Dates:  | sedent's Usual Occupation ye kind of work done during most of work DO NOT use retired) Homemaker | rking 16b. I  | Kind of Business/Industry  Home   |
| Maryland 2   | d Mental Hygie<br>d Mental Hygie<br>narkad othar i<br>natic event, II  | To Be Co          | 12th 17. Father's Name (First, Middle, Last)  John Wesley H  19a. Informant's Name/Relationship (Type, Prince)   | larvey, Jr.   |  | ne (First, Middle, Maide<br>Mildred                           | n Surname)<br>Childs  |
|              | permit. Pages 1 and 2 st<br>Department of Health and<br>Important: If item 27 is r<br>any injury or other traur<br><u>once</u> .   |                   | Gary B. Cooper/son  20a. Method of Disposition  1   Burial 2 □ Cremation 3 □ Remova  | 1066<br>20b. Place of Dis<br>cometery, cr   | 5 Wilson-Corona Ro<br>position (Name of<br>rematory or other place)                              | ad, Oakland   | , Md. 21550<br>Location - City or Town, State   |
| Baltimore,   | permit. Pa<br>Departmer<br>Important<br>any injury   |                   | 21. Signature of Funeral Service Licenses  |   | 22. Name and Address of Facility Stewart Funeral Ho  | 32 S<br>me Oakl   | s. Second St. and, Md. 21550  |
|              | Physician<br>/Medical<br>Examiner  |                   | 23a. Part1. Enter the disease, or complications shock, or heart failure. List only one caus Immediate Cause (Final disease or condition resulting in death)  | se on each line.  | nol failure  | on respiratory arrest,  | Interval Between Onset and Death  |
| 1760,        | te be executed<br>ysician and<br>te burial-transit   | ical Examiner     | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, (Disease or injury that initiated events resulting in death) Last  | Longestive  Thew sc ttc  Jue to (or as a consequence of):                                   | - Corlosscular   | diene   | 5 years   |
| .O. Box 68   | The law requires that the death certifica<br>tie has been signed by the attending ph<br>page 2 should be detached for use as th  | Physician/Med     | in the past 12 months?   |   | 3 □Ectopic pregnancy<br>5 □ Other (specify)  |   | 23d. Date of delivery<br>Month Day Year   |
| rds, P       | n requires that<br>been signed b<br>should be deta   | by                | Part II. Other significant conditions contribution  Diabetes Melli   | ng to death but not resulting in the  | e underlying cause given in Part I. $\omega_0$   | 23e. Did tobacco  | ouse contribute to the cause of death?  2 No 3 Probably 4 Unknown                       |
| al Records,  |  | e Completed       | pneumonia  25. Was case referred to medical  | intection   | 26. Place of Cie   | 24a. Was an autopsy performed? 1 Yes 2 N ath (Check only one) | 24b. Were autopsy findings available prior to completion of cause of death?  1 Yes 2 No |
| ion of Vital | ding Phye  | To B              | examiner?<br>1 ☐ Yes 2 ☐ No Hospita  | l: 1 npatient 2 ER/Outpat  Date of Injury (Month, Day Year) 28b. Time Injury                | ient 3 DOA Other: 4 Nursing i  | Home 5 Residence<br>28d. Describe how inj                     |   |
| Division     | F 8 F C  | Il Certification: | 4  Homicide  | Place of Injury - At home, farm, building, etc. (Specify)  To the best of my knowledge, de- | street, factory, office  | City or Town, Sta   |   |
|              | To the Hospitel of within 24 hours at To the Funeral D completely filled in  | Medical           | (Check only 2 Medical Examiner: O ar   | n the basis of examination and/or<br>nd manner stated.                                      | investigation, in my opinion, death occ  | urred at the time, date a                                     | nd place, and due to the cause(s)   |
|              | 10   |                   | 30. Name and address of person who completed by the complete and the compl | ed cause of death (Item 23a) (Type ann MD PO  | Box 247, Accid   | den + MD  | 121520  |
|              | St<br>Regist   | ate               | 31. Date filed (Month, Day, Year) 4 200  | 32. Registrar's Signature   | A of   |   |   |

|                            |  | •              | 1 - For<br>State<br>Registrar  | State of  | Marylai                       |                    | epartment of<br>Certificate of                   |  | Mental Hy                            | giene<br>Reg. No. 00          | 5 41924   |
|----------------------------|--|----------------|--|---|-------------------------------|--------------------|--|--|--------------------------------------|-------------------------------|---|
|                            |  |                | Decedent's Name (First, Middle   | , Last)   |                               |                    |  |  | 2. Date of De                        | aath                          | 3. Time of Death  |
|                            | Physici  |                | DARRELL W. DUAN  | JE. SR  |                               |                    |  |  | Decemb                               |                               | 005 01:25 M   |
|                            | /Medic<br>Examin   |                | 4a. Facility Name (If not institution  |   | er)                           |                    | 4b. City, Town,                                  | or Location of Deat                        |                                      | 4c. County of                 |   |
|                            | LAGIIIII   | C1             | Peninsula Reg  | inal mad  | 10/                           | Canto              | 501  | ichica                                     |                                      | Wicen                         |   |
|                            | Funeral  |                | 5. Social Security Number  | 6. Sex 7.                                       | Age (In yrs                   | . last birtho      | ay) If Under 1 Year                              |  |                                      |                               | Birthplace (State or Foreign Country)                       |
|                            | Director   |                | 568-12-9955  | 1∰M 2□F   | 82                            | Yr                 | Months Days                                      | Hours Min.                                 | 09-13-                               | ау, <i>Үөаг)</i><br>1923 — СА | ALIFORNIA   |
|                            | ס  |                | Usual Residence of Decedent  |   |                               |                    |  |  |                                      |                               |   |
|                            | nylan<br>how   | .              | 10a. State 10b. County   |   | 10c. C                        | ity, Town o        | r Location                                       |  |                                      |                               | 10d. Inside City Limits                                     |
|                            | Ma<br>P-f  | Director       | MD WORCE   | ESTER   | BER                           | LIN                |  |  |                                      |                               | 1 ☐ Yes 2/ No   |
|                            | th the   | ire            | 10e. Street and Number   |   |                               |                    | 10f. Zip Code                                    |  |                                      | 10g. Citizen of Wha           | at Country?   |
|                            | 15 will  | aic            | 157 NOTTINGHAM   | LANE  |                               |                    |  | 21811                                      | i                                    | USA                           |   |
|                            | dea  | Funerai        | 11. Marital Status   | 12. Was Decede                                  | ent Ever in U                 | J.S.               | 13. Was Decedent of                              | Hispanic Origin? (S<br>pan, Mexican, Puer  | Specify Yes or No                    |                               | American Indian,<br>White, etc.                             |
| ٥                          | or it  |                | 1 ☐ Never Married 2 💢 Marri  | Armed Force od 1 XYes 2                         | □ No                          | ı                  | 1 ☐ Yes 🏋 ☐ No                                   |  | to ritioan, etc.)                    | Specify:                      | WHITE   |
| $\Xi$                      | ours<br>irei;  | dby            | 3 Widowed 4 Divorced   | If Yes, Give<br>Year or Date                    | esl 943–                      | 46                 | TE 103 AE 110                                    | opecity.                                   |                                      | Зреспу.                       | MULTE   |
| 9500-61212                 | filed within 72 hours after death with the Maryland<br>Hygiene.<br>Wher than "naturel; or Iteme 23a or 28e-f ehow<br>Int, the Medical Examinat must be notified at | Completed      | 15. Decedent<br>(Specify only highes   |   |                               | (0                 | ecedent's Usual Occu                             | during most of wo                          | rking                                | 16b. Kind of Busin            | ess/Industry  |
| 7                          | ithin<br>nan<br>nan  | d E            | Elementary/Secondary (0-12)  | College (1-4                                    | or 5+)                        |                    | e. DO NOT use retire                             |  |                                      | 00115777                      | TEL CONTEND LONG  |
|                            | Hygier<br>Hygier<br>ther ti  | ខ              |  | 4   |                               | ELEC               | TRICAL EN  | T  |                                      |                               | NT CONTRACTS  |
| Maryland                   | a a b ≥  | Be             | 17. Father's Name (First, Middle, I  |   |                               |                    |  |  |                                      | , Maiden Sumame)              |   |
| $\frac{8}{5}$              |  | ၉              | RICHARD GEORGES  |   |                               | _                  |  |  | Y BELL                               |                               |   |
| ā                          | CA 40 00 00  |                | 19a. Informant's Name/Relationsh   |   |                               | 3                  | ailing Address (Stree                            |  |                                      |                               |   |
|                            | an and   |                | MARTHA DUANE -   | SPOUSE  | 1005                          | _                  | NOTTINGHAL                                       | M LANE, B                                  |                                      |                               |   |
| 5                          | @ C  |                | 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation  | 3 ☐Removal from St                              | 1                             | cemetery,          | sposition (Name of<br>crematory or other pla     | 300)                                       | Date                                 | 20c. Location - Cit           | y or Town, State  |
| altimore,                  | Peges<br>ment of<br>ent: if it   |                | 4 □Donation 5 □ Other (Sp  | pecify)   |                               | ERLY               | FUNERAL H  |  | 3-2005                               | FAIRFAX,                      |   |
| ğ                          | permit. Pege<br>Depertment of<br>Importent: if<br>eny injury of<br>once.   |                | 21. Signature of Funeral Service   | icensee   |                               |                    |  |  |                                      | NERAL HOME                    |   |
| n<br>—                     | 405 a  |                | 1/081550 T   | ley Hour  |                               |                    |  |  |                                      |                               | LAND 21804  |
|                            |  |                | 23a. Part1. Enter the disease, or shock, or heart failure. List  | emplications that au<br>only one cause on eac   | sed the dea<br>h line.        | th. Do not         | enter the mode of dy                             | ing, such as cardia                        | c or respiratory a                   | rrest,                        | Approximate<br>Interval Between                             |
|                            | Physician  |                | Immediate Cause (Final disease or condition  | Da  | eumoc                         | occal              | 2 preum  | ioma.                                      |                                      |                               | Onset and Death   |
|                            | /Medical   |                | resulting in death)  |   | as a conse                    |                    |  | 0,000                                      |                                      |                               |   |
|                            | Examiner   |                | Sequentially list conditions   | to be   | ma                            | Cor                | Cer  |  |                                      |                               |   |
|                            | <i>p</i> ≈ <i>q</i>  | ner            | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying                       | Due to (or                                      | as crise                      | quence of)         |  |  |                                      |                               |   |
|                            | ocute<br>nd<br>trans   | Examin         | cause. Enter Underlying<br>Cause (Disease or injury<br>that initiated events<br>resulting in death) Last | c. (2)  | Con                           | COV                | rcer   |  |                                      |                               |   |
| Š,                         | icate be executed<br>physicien and<br>s the burial-transit   |                | resulting in death) case   | Due to (or                                      | as a conse                    | quence of)         |  |  |                                      |                               |   |
| 8760                       | ate b  | dicai          |  | d.  |                               |                    |  |  |                                      |                               |   |
| 9                          | ing p  |                | IF FEMALE:   |   |                               |                    |  |  |                                      |                               |   |
| X<br>Q<br>Q                | death certifi<br>e attending  <br>d for use as   | lan/           | 23b. Was decedent pregnant in the past 12 months?  | 23c. If yes, outco<br>1 ☐ Live birt             | n 2 🗆 Fet                     | al death           | 3 □Ectopic pregnand                              | су   |                                      | 23d. Date o<br>Month          | f delivery Day Year   |
| 0                          | 0 0 0  | Physician/M    | 1 Yes 2 No<br>9 Unknown  | 4□Pregnar<br>9□Unknow                           |                               | death              | 5 ☐ Other (specify) _                            |  |                                      |                               | ouy rour  |
| <u>.</u>                   | iaw requires that the<br>as been signed by th<br>2 should be detache   | E              |  |   |                               |                    |  | 's Boat                                    | aan Dida                             |                               | ite to the cause of death?                                  |
| ś                          | signed b   | 2              | Part II. Other significant condition   | is contributing to deal                         | m but not re                  | suiting in tr      | e underlying cause g                             | ven in Parti.                              |                                      |                               | Probably 4 Unknown  |
| 5                          | w require<br>been si<br>should t   | ted            |  |   |                               |                    |  |  | ,                                    | Yes 2 No 3 €                  | Probably 4 Unknown  |
| ပိ                         | iaw<br>ias b   | Completed      |  |   |                               |                    |  |  | 24a. Was                             | psy prio                      | e autopsy findings available<br>r to completion of cause of |
| r                          | The law<br>sete has<br>page 2.1  | 5              |  |   |                               |                    |  |  | perfo<br>1 ☐ Yes                     | ormed? dea<br>2 no 1 □        | th?<br>Yes 2∐ No  |
| <u>=</u>                   | sien:<br>ertific<br>ictor,   | Be             | 25. Was case referred to medical examiner?   |   | _                             |                    |  |  | ath (Check only                      | one)                          |   |
| <u> </u>                   | hysic<br>his co  | ဥ              | 1 ☐ Yes 2 ☑ No   | Hospital: 1 Inp                                 | atient 2                      | ER/Outpa           | III 30 DOA                                       |  | lome 5 ☐ Resi                        | dence 6 Other (               | Specify)  |
|                            | Attending Physicien: or death. ector: After this certific by the funeral director.   | ü              | 27. Manner of Death 1 ☑Natural 5 ☐ Pending   | 28a. Date of (Month,                            | Injury<br>Day Year)           | 28b. Tim<br>Inju   |  | iry at<br>ork?                             | 28d. Describe                        | how injury occurred           |   |
| Division of Vital Records, | eath.<br>or: A   | cati           | 2 Accident investig  | ation   |                               |                    | M 10   | ]Yes 2□No                                  |                                      |                               |   |
| ₹                          | tei or Attendir<br>s after death.<br>ai Director: A<br>ed in by the fu   | Certification: | 4 Homicide determi   | ned   286. Place of                             | Injury - At h<br>, etc. (Spec | nome, farm<br>ify) | , street, factory, office                        |  | 28f. Location (<br>City or To        |                               | or Rural Route Number,                                      |
| _                          | spitei cours af  |                |  |   |                               |                    |  | VA TWO EXPLORED TO THE                     |                                      | a mission of the contract     |   |
|                            | To the Hospitel or A within 24 hours after To the Funeral Direction Completely filled in by  | Medicai        | 29a. Certifier 1 Certifyin (Check only one) 2 Medical I  | g Physician: To the he<br>Examiner: On the basi | is of examin                  | ation and/o        | enth consumed at the t<br>r investigation, in my | ime, date and place<br>opinion, death occu | and due to the<br>urred at the time, | date and place, and           | or as stated.  I due to the cause(s)                        |
|                            | To the Horwithin 24 h To the Fur   | Med            | 29b. Signature and title of certifier  | and manne                                       | r stated.                     |                    | 29c Licen  | se number                                  | Т                                    | 29d. Date signed (A           | Aonth Day Yeart   |
|                            | T X T S  |                | Signature and the or contine   | -mp   |                               |                    | 1  | 4127                                       |                                      |                               |   |
|                            | 713  |                |  |   | -4 a                          | - 00 : -           | 1 //3  |  |                                      | 12/                           | 0103  |
|                            | 1 2  | İ              | 30. Name and address of person of PAVIS  | wno completed cause                             | of death (Ite                 | m 23a) (Ty         | pe, Print)                                       | Salis                                      | hurn                                 | 12/3<br>mp                    | 21804   |
|                            | Sta  | to             | 31. Date filed (Month, Day, Year)  |   | istrar's Sion                 | ature              | , -,   |  | 1                                    |                               |   |
|                            | Registr  |                | DEC 1  | 2 2005  | istrar's Sign                 | S.                 | Street<br>Spelle                                 |  | U                                    |                               |   |
|                            |  |                |  | AT CAPPED                                       | THE WATER TO THE PERSON TO    | A 100              | Who die and the same                             |  |                                      |                               |   |

|                   |  |                   | For State   | State of Ma   | arylan      | -                |                        |                   | lealth a                   |                           |                                       | giene                | $\cap$ $\cap$ $\square$  |                      | 11925  |
|-------------------|--|-------------------|---|---|-------------|------------------|------------------------|-------------------|----------------------------|---------------------------|---------------------------------------|----------------------|--------------------------|----------------------|--|
|                   |  |                   | Registrar  1. Decedent's Name (First, Middle)   | , Last)   |             |                  | timodi                 | 0 07 .            |                            |                           | 2. Date of Dea                        | th                   |                          |                      | 3. Time of Death                             |
|                   | Physici  |                   | Vera M  | Marie Da  | avis        | -Ford            |                        |                   |                            |                           | Month                                 | Day                  | 0 200                    |                      | 1051 M                                       |
|                   | /Medic<br>Examin   |                   | 4a. Facility Name (If not institution,  | give street and number)                               | ^           | 0 1              | 4b. City,              | Town, or          | Location                   | of Death                  |                                       | 4c.                  | County of D              | eath                 |  |
|                   |  |                   | Peninsula Regi  | onal Medic  | cal (       | ener             | Sal                    | Lishu             |                            |                           |                                       | U                    | Jicor                    | MiC                  | <i>O</i>                                     |
|                   | Funeral  |                   | 5. Social Security Number   | - I   |             | ast birthday)    | If Under<br>Months     | 1 Year<br>Days    | If Under<br>Hours          | 24 Hrs.<br>Min.           | 8. Date of Birth<br>(Month, Day       | (Year)               | 9.                       | Birthpt:<br>Count    | ace (State or Foreign                        |
|                   | Director   |                   | 220-52-8628   | 1□M 2⁄2F 5  |             | Yrs.             |                        |                   |                            |                           | Jan.6                                 | , 19!                | 04                       |                      | Pa   |
|                   | and w  |                   | Usual Residence of Decedent  10a. State 10b. County   |   | 10c. City   | , Town or Lo     | cation                 |                   |                            | -                         | , , , , , , , , , , , , , , , , , , , |                      |                          | 10                   | d. Inside City Limits                        |
|                   | Mary<br>f she  | ō                 | Md. Wicon   | nico  | s           | alisb            | urv                    |                   |                            |                           |                                       |                      |                          |                      | 1 ☑ Yes 2 ☐ No                               |
|                   | r 28a  | Irec              | 10e. Street and Number  |   |             |                  | 10f. Zip               | Code              |                            |                           |                                       | 10g. Citi            | zen of What              | Count                | ry?  |
|                   | Ih will<br>23a o<br>Ist bs   | Funeral Director  | 611 Lake st   |   |             |                  |                        | 218               | 01                         |                           |                                       | US                   | SA                       |                      |  |
|                   | ems<br>L   | ner               | 11. Marital Status  | 12. Was Decedent I<br>Armed Forces?                   | Ever in U.  | S. 13. V         | Was Dece<br>f Yes, spe | dent of H         | ispanic Ori<br>in, Mexicar | igin? (Spe<br>n, Puerto F | cify Yes or No-<br>Rican, etc.)       |                      | 14. Race - A<br>Black, W |                      |  |
| 36                | or it  | by Fu             | 1 Never Married 2 Marri   | If Yes, Give  | No          | -                | ¹ □ Yes                | 2√2 No            | Specify:                   | :                         |                                       |                      | Specify: B               | lad                  | ck   |
| 21215-0036        | within 72 hours after death with the Maryland<br>ene.<br>Than "natural", or Items 23a or 28a-f show<br>the Medical Examinar must be notilled at  | ed b              | 3 ☐ Widowed 4 ☐ Divorced  15. Decedent  | Year or Dates:  |             | 16a. Deced       | ient's Lisu            | al Occup          | ation                      |                           |                                       |                      | nd of Busine             |                      |  |
| 5                 | in 72  | Completed         | (Specify only highes  | t grade completed)                                    |             | (Give            | kind of wo             | ork done o        | during mos                 | st of working             | ng                                    | 100.14               |                          |                      | aou,   |
| 72                | iene.  | E                 | Elementary/Secondary (0-12)   | College (1-4or 5                                      | )<br>)      | Dome             | stic                   | : En              | gine                       | er                        |                                       | Hot                  | tel                      |                      |  |
| פַ                | othe<br>vent,  | BeC               | 17. Father's Name (First, Middle, L   | .ast)   |             |                  |                        |                   |                            |                           | (First, Middle,                       | Maiden               | Sumame)                  |                      |  |
| <u> a</u>         | Ventz<br>Mentz<br>rrked  | 2                 | Azo Da  | avis  |             |                  |                        |                   | Ro                         | sett                      | a Col                                 | lbui                 | rne                      |                      |  |
| Maryland          | 2 sho<br>and I<br>is ma  | 10 1              | 19a. Informant's Name/Relationsh  |   |             |                  | -                      |                   |                            |                           | Route Numbe                           |                      |                          |                      |  |
| <u>∞</u>          | and<br>lealth<br>m 27  |                   |   | son/siste   |             | lace of Dispo    |                        |                   | est                        |                           | Felto                                 |                      | cation - City            |                      |  |
| 5                 | or of  |                   | 20a. Method of Disposition  |   | Md.         | emetery, cren    | natory or c            | other plac        | me -                       |                           |                                       |                      | rlock                    |                      |  |
| Baltimore,        | permit. Peges 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: if Item 27 is marked other than "natural; or Itema 23a or 28a-f show eny Injury or other traumatic event, the Medical Examinar must be notified at pre- |                   | 4 Donation 5 Other (Sp. 21. Signature of Funera Service L   |   | )           |                  |                        |                   |                            |                           |                                       |                      |                          | •                    | al Home                                      |
| Ba                | Depa<br>Impo   |                   | 1)  | -11   |             |                  |                        |                   |                            |                           |                                       |                      |                          |                      | 1.21801                                      |
|                   |  |                   | 28e. Part1 Enter the disease, or  | complications that caused                             | the death   | n. Do not ent    | er the mod             | de of dyin        | g, such as                 | cardiac o                 | r respiratory ari                     | rest,                |                          |                      | Approximate<br>Interval Between              |
|                   | Physician  |                   | shock, or heart failure. List of Immediate Cause (Final   | my one cause on each in                               | 110.        | 140              | 8 64                   | ules              |                            |                           |                                       |                      |                          |                      | Onset and Death                              |
| 1                 | /Medical   |                   | disease or condition resulting in death)  | Due to (or as   | a conseq    |                  | Q                      |                   |                            |                           |                                       |                      |                          | +                    |  |
| я                 | Examiner   |                   | Sequentially list conditions.   | b   |             |                  |                        |                   |                            |                           |                                       |                      |                          |                      |  |
|                   | sit ad   | lner              | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | Due to (or as   | a conseq    | uence of):       |                        |                   |                            |                           |                                       |                      |                          |                      |  |
|                   | and<br>and<br>Il-tran  | Examiner          | that initiated events<br>resulting in death) Last   | c. Due to (or as                                      | a conseq    | uence of):       |                        |                   |                            |                           |                                       |                      |                          | +                    |  |
| 8760,             | sate be executed<br>physicien and<br>the burial-transit  | alE               |   |   |             |                  |                        |                   |                            |                           |                                       |                      |                          |                      |  |
| 687               | ficate<br>physics the  | edic              |   | d   |             |                  |                        |                   |                            |                           |                                       |                      |                          |                      |  |
| Вох               | death certifica<br>a ettending ph<br>ad for use as th  | n/M               | IF FEMALE:<br>23b. Was decedent pregnant  | 23c. If yes, outcome<br>1□Live birth                  |             |                  | Ectopic p              | roonana           |                            |                           |                                       |                      | 23d. Date of             | deliver              | у  |
| œ.                | death  | sicla             | in the past 12 momths?<br>1 ☐ Yes 2 ☑ No  | 4□Pregnant at   |             |                  | Other (s)              |                   |                            |                           |                                       | 186                  | Month                    | 1                    | Day Year                                     |
| P.O.              | law requires that the de<br>as been signed by tha e<br>2 should be detached f  | Physician/Medical | 9 ☐ Unknown   |   |             |                  |                        |                   |                            |                           | 00. 014                               | 100                  |                          |                      |  |
|                   | res tha<br>signed I<br>I be det  | þ                 | Part II. Other significant condition  | ns contributing to death b                            | ut not res  | ulting in the ui | nderlying              | cause giv         | en in Parti                | I.                        |                                       | es 2                 |                          | e to trie<br>] Proba | cause of death?                              |
| oro               | w require<br>been si<br>should l   | Completed         |   |   |             |                  |                        |                   |                            |                           | -                                     | -                    | 1000 0                   | _                    | •  |
| Sec.              | 0 5 0  | Jd III            |   |   |             |                  |                        | -                 |                            |                           | 24a. Was a<br>autop                   |                      | 24b. Were prior deati    | to com               | sy findings available<br>pletion of cause of |
| of Vital Records, | T ale  |                   |   |   |             |                  |                        |                   |                            |                           | 1 Tes                                 | 2 🗖 No               | 10                       | res :                | 2 No   |
| ₹                 | Physiclan:<br>r this certific<br>ral director,   | o Be              | 25. Was case referred to medical examiner?  1 Yes 2 No  | Hospital:   | ant 2 🗆     | ER/Outpatien     | nt 3 D                 | Oth               | 00                         |                           | ne 5 ☐ Resid                          |                      | E DOther /               | Page h               |  |
| o                 | g Phys<br>er this<br>eral di   | n: To             | 27. Manner of Death   | 28a. Date of Inju                                     | iry         | 28b. Time of     |                        | 28c. Injur<br>Wor |                            |                           | 28d. Describe h                       |                      |                          | эрвспу               |  |
| <u>o</u>          | Attending Indeath.   | atio              | 1 ☐Natural 5 ☐ Pending 2 ☐ Accident investig  |   | y rear)     | Injury           | М                      |                   | Yes 2                      | No                        |                                       |                      |                          |                      |  |
| Division          | I or Atten<br>after deat<br>Director:  | Certification:    | 3 ☐ Suicide 6 ☐ Could r<br>4 ☐ Homicide determ  |   |             |                  | eet, factor            | y, office         |                            | 2                         | 28f. Location (S<br>City or Tow       | treet an<br>n, State | d Number o               | r Rurai              | Route Number,                                |
| 0                 | itel or<br>irs afte<br>rel Dir<br>led in   |                   |   |   |             |                  |                        |                   |                            |                           |                                       |                      |                          |                      |  |
|                   | To the Hospitel or Attending Physician: within 24 hours after death. To the Funerel Director: After this certific completely filled in by the funeral director.  | edical            |   | g Physicien: To the best<br>Examiner: On the basis of | f examina   |                  |                        |                   |                            |                           |                                       |                      |                          |                      |  |
|                   | To the within 2 To the complet   | Med               | 29b. Signature and title of certifier   | and manner sta  | ated.       |                  | 29                     | c. Licens         | e number                   |                           |                                       | 29d. Dat             | e signed (M              | onth, E              | Pay, Year)                                   |
|                   | F 3 F 8  |                   | Nº Ku   |   |             |                  |                        |                   | 1094                       |                           |                                       |                      | 110/0                    |                      | ·  |
|                   |  |                   | 30. Name and address of person  |   | leath (Iten | n 23a) (Type.    | Print)                 |                   |                            |                           |                                       |                      |                          |                      | 617.   |
|                   |  |                   | VC1 NATE 8  |   | 1415        | 5.0              | 11/5/6                 | <i>U</i> ~ 5      | 57                         | 54                        | e 15AW                                | ry                   | MD                       | 20                   | 04   |
|                   |  | ate               | 31. Date filed (Month, Day, Year)   | 32. Registr   | _           |                  |                        | _                 |                            |                           |                                       |                      |                          |                      |  |
|                   | Regist   | rar               | Bell Son half also  | FO ZUUJI PERL   | Partie or   | Re a             | Maga A                 | F                 |                            |                           |                                       |                      |                          |                      |  |

|     |  |   | •                | For Amend Items State Registrar  | us 29er;v;                                       | Cyrtai   | Cei   | tificate of                              | Death                                   |  | Reg NoU U                                  | 5                       | 1926  |
|-----|--|---|------------------|--|--|--|---|--|---|--|--|-------------------------|---|
|     |  | Physicia  | ın               | 1. Decedent's Name (First, Middle  | Marie  | Do.  | lton  |  |   | 2. Date of De                            | er <sup>Day</sup> 20                       | o <sup>Year</sup>       | 3. Time of Death 3:42 AM M                    |
|     |  | /Medic  | al :             | Ethel 4a. Facility Name (If not institution  |  |  | LLOII                                       | 4b. City, Town, o                        | r Location of Dea                       |  | 4c. Count                                  |                         |   |
|     |  | Examin  | ęr               | Wicomico Nur   |  |  |   |  | isbury                                  |  | Wico                                       |                         |   |
|     |  | Funeral<br>Director   |                  | 5. Social Security Number 217–09–7420  | 6. Sex<br>1 ☐ M 2 🔼 F                            | 7. Age (In ye                                  | rs. last birthday)<br>Yrs.                  | If Under 1 Year<br>Months Days           | If Under 24 Hrs<br>Hours Min            |  | v, Year)                                   | Cou                     | place (State or Foreign<br>ntry)<br>'land     |
|     |  | pu 🖈  |                  | Usual Residence of Decedent  10a. State 10b. County  |  | 10c.   | City, Town or Lo                            | cation                                   |   |  |  |                         | 10d. Inside City Limits                       |
|     |  | Maryla<br>f eho   | jo               |  | omico  |  | Salisbu                                     | ıry                                      |   |  |  |                         | 1 <b>X</b> Yes 2□No                           |
|     |  | death with the Maryland ms 23e or 28e-f ehow  | i Director       | 10e. Street and Number<br>900 Booth St.  |  |  |   | 10f. Zip Code<br>2180                    | 1                                       |  | 10g. Citizen of US                         |                         | intry?  |
|     | 9                                      | s 1 and 2 should be filed within 72 hours after death with the Marylan if Healinth and Mental Hygiene. If the and the filed within and Mental Hygiene 7 learns 23e or 28e-f ehow titem 27 learns that do ther than "naturel", or lieurs and be notified at other treumatic event, the Modical Exp. in or round be notified at | / Funeral        | 11. Marital Status  1 Never Married 2 Marr   | Amed F   | 2 🔀 No   |   | Was Decedent of HI Yes, specify Cuba     |   | Specify Yes or Norto Rican, etc.)        | Bla  | ce - Amer<br>ick, White |   |
| \   | . 003                                  | hours<br>turel',  | ed by            | 3 ☐ Widowed 4 ☐ Divorced   | Year or  | Dates:   | 16a, Dece                                   | dent's Usuai Occur                       | ation                                   |  | 16b. Kind of E                             |                         |   |
| ž   | 215                                    | hin 72<br>s.<br>nn °na<br>Madic   | Completed        | (Specify only higher<br>Elementary/Secondary (0-12)  | st grade completed                               | (1-4or 5+)                                     | (Give                                       | kind of work done<br>DO NOT use retired  | during most of wo                       | orking                                   |  |                         | ,   |
| Har | 21                                     | ed with   | Com              | 12   | 2  |  | Polit                                       | ical Con                                 |   | ame (First, Middle                       |  | sult:                   | ing   |
| a   | and                                    | d be fill<br>antal H<br>ed oth  | Be               | 17. Father's Name (First, Middle, Harry E. Hayne   |  |  |   |  |   | ine Lana                                 |  | me)                     |   |
| 0   | Maryland 21215-0036                    | d 2 should and Me To mark   | To               | 19a. Informant's Name/Relations Joan B. Seiler   | hip (Type, Print)                                |  |   | ng Address (Street                       | and Number or F                         | Rural Route Numb                         | er, City or Town                           |                         | p Code)                                       |
| 10/ | nore,                                  | Pages 1 an<br>nent of Heal<br>out: If item 2<br>ury or other  |                  | 20a. Method of Disposition  1 Burial 2 Commation   |  | State  |   | esition (Name of<br>matory or other plan | 112/                                    | Date 10/05                               | 20c. Location                              |                         |   |
| 14  | Baltimore,                             | permit. Pages 1 ar<br>Department of Hea<br>Importent: If item<br>any injury or othe<br>once.  |                  | *4 □ Donation 5 □ Other (S<br>21. Signature of Funeral Service   | -  |  | CO 1  |  | ss of Facility<br>Funeral               | Home Pro                                 | fession                                    | al As                   | ssociation                                    |
|     |  | /Medical // // // // // // // // // // // // //   | al Examiner      | 23a. Part 1. Enter the disease, or shock, or heart failure. List immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | a. Ser<br>Due to<br>b. Er<br>c. Pivi             | o (or as a cons                                | Left Hip<br>sequence of):<br>Posquence of): | Fractur                                  | e with c                                | MANIEDICO                                | ions                                       |                         | Onset and Death                               |
|     | Division of Vital Records, P.O. Box 68 | ath certific<br>ttending p<br>for use as  | hysician/Medical | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes ₩ No 9 □ Unknown  | 1 ☐ Live   | utcome of pre<br>birth 2 F<br>gnant at time on | etal death 3                                | □Ectopic pregnanc                        |   |  | 23d. D                                     | ate of deli             | very<br>Day Year                              |
|     | ds, P.                                 | uires that the de<br>signed by the a<br>id be detached to   | by P             | Part II. Other significant conditi   | ons contributing to                              |  | _   | ınderlying cause gı                      | ven in Part I.                          |  | tobacco use cor<br>Yes 2 □ No              | ntribute to<br>3 ☐ Pro  | the cause of death?                           |
|     | Recor                                  | The law require<br>ate has been sip<br>page 2 should b  | Completed        |  |  |  |   |  |   | 24a. Wa<br>auto<br>peri<br>1 □ Yes       | s an 24b<br>opsy<br>ormed?/<br>2DNo        | death?                  | opsy findings available ompletion of cause of |
|     | /ita                                   | iding Physicien: Th<br>th.<br>: After this certificate<br>s funeral director, pag   | Be               | 25. Was case referred to medical examiner?   |  |  |   | Ott                                      | 26. Place of Di                         | eath (Check only                         | one)                                       |                         |   |
|     | of                                     | Physic<br>this c  | - T              | 1 Yes 2 18   |  |  | 2 ER/Outpatie                               | of 28c. inju                             | ry at                                   | Home 5 ☐ Res<br>28d. Describe            | how injury occu                            |                         | ify)  |
|     | lon                                    | ttending<br>death.<br>stor: After<br>the fune   | ation            | Natural 5 ☐ Pendi  |  | e of Injury<br>onth, Day Yea<br>1/2005         | r) Injury Unknov                            | Wo                                       | rk?<br>]Yes 2                           | Sub jed                                  | et fell                                    |                         |   |
|     | Divis                                  | I or Attend<br>after death<br>Director: /   | ertification:    | 3 Suicide 6 Could 4 Homicide deterr  | not be<br>nined 28e. Pla<br>bui                  | ce of Injury - A                               | mc)   | reet, factory, office                    |   | 281. Location<br>5111 C                  | (Street and Num<br>own, State)<br>Onnectio | ut A                    | ral Route Number, Ve.,N.W.                    |
|     |  | To the Hospital or Attending Physicien: within 24 hours after death. To the Funeral Director: After this certifica gompletely filled in by the funeral director, and the funeral director.  | edical C         | 29a. Certifier 1 Certifyi (Check only one) 1 Medicel   | ng Physicien: To t<br>Examiner: On the<br>and ma | he best of my                                  | knowledge, dea                              | th occurred at the tinvestigation, in my | me, date and place<br>opinion, death oc | ce, and due to the<br>curred at the time | cause(s) and n                             | nanner as<br>, and due  | stated.<br>to the cause(s)                    |
| _   |  | To th within To th Sompl  | Me               | 29b. Signature and title of certific   | er   |  |   | 29c. Licen                               |   |  | 29d. Date sign                             | ed (Month               | , Day, Year)                                  |
|     |  | · H   |                  | 1 you  |  | 32   |   |  | 006319                                  | 7.                                       | 12/9                                       | 201                     |   |
|     |  | 12  |                  | 30. Name and address of person   |  |  |   |  | huma im                                 | 21904                                    |  |                         |   |
|     |  | Sta   | ate              | Yogesh Vohra 1<br>31. Date filed (Month, Day, Year<br>DEC 1  | 1 32   | Manistrar's S                                  | ignature                                    | Dr Salis                                 | bury MD                                 | 21004                                    |  |                         |   |

|             |   |                     | 1 - For<br>Stete<br>Registrar  |  | artment of Health and Martificate of Death  | lental Hygier<br>Reg. t                         | 000= 1  | 1927                                 |
|-------------|---|---------------------|--|--|---|---|---|--------------------------------------|
|             | Physicia  | an                  | Decedent's Name (First, Middle, Last)  |  |   | 2. Date of Death<br>Month                       | ay Year   | ime of Death                         |
|             | /Medic  | al                  | Adeline Dize   |  |   | December 9                                      | 9, 2005   12  | 240 M                                |
|             | Examin  | er                  | 4a. Facility Name (If not institution, give : Alice Byrd Tawes N   |  | 4b. City, Town, or Location of Death Crisfield  | 1   | c. County of Death Somerset                               |                                      |
|             | Funeral   |                     | 5. Social Security Number 6. Sex   | 7. Age (In yrs. last birthday)   | If Under 1 Year If Under 24 Hrs.  | 8. Date of Birth<br>(Month, Day, Yea            |   | State or Foreign                     |
| Ĺ           | Director  |                     | Usual Residence of Decedent  | M 200 F 88 Yrs.  | Months Days Hours Min.  | 02-23-191                                       | 17   Marylar  | 1d                                   |
|             | Marylar<br>B-f show   | tor                 | 10a. State 10b. County  MD Somerset  | 10c. City, Town or L   |   |   |   | Yes 2 □ No                           |
|             | ith the   | Oire                | 10e. Street and Number   |  | 10f. Zip Code   | 10g. (  | Citizen of What Country?                                  |                                      |
|             | s 23a   | rai                 | 201 Hall Highway   |  | 21817   |   | USA   |                                      |
| 36          | permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mentall Hygiene. Important: if them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Madical Examiner must be notified at sec. | by Funeral Director | 11. Marital Status  1 Never Married 2 Married  Widowed 4 Divorced  | 1 ☐ Yes 2 No   | Was Decedent of Hispanic Origin? (Speif Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 No Specify: | cify Yes or No-<br>Rican, etc.)                 | 14. Race - American Ind<br>Black, White, etc.<br>Specify: | ian,                                 |
| 21215-0036  | 2 hour  | ted t               | 15. Decedent's Edu   | cation 16a. Dece   | dent's Usual Occupation   | 16b.  | White Kind of Business/Industry                           |                                      |
| 275         | thin 72<br>9.<br>Madi   | ple                 | (Specify only highest grade<br>Elementary/Secondary (0-12)   | College (1-4or 5+) (Give life.   | kind of work done during most of worki<br>DO NOT use retired)                                     | ng  | ,   |                                      |
| 7           | ed wii<br>ygien<br>ner th<br>it, Ire  | Completed           | 11   |  | sh Maker  |   | ıbberset Comp   | any                                  |
| and<br>E    | be fill<br>tal H<br>od oth  | Be                  | 17. Father's Name (First, Middle, Last)  |  |   | (First, Middle, Maide                           | en Sumame)  |                                      |
| Maryland    | hould<br>d Mer<br>marke<br>maric  | ဥ                   | Robert Sterling  19a. Informant's Name/Relationship (Ty)   | na Print) 19h Maili  | Allie M   |   | or Tourn State Tin Code                                   |                                      |
| Ma          | od 2 s<br>Ith an<br>27 ia<br>r trau   |                     | Vicki Dize/daughte   | r-in-law   |   |   | B ARABUNSHAN  |                                      |
| ē,          | is 1 ar   |                     | 20a. Method of Disposition   | 20b. Place of Dispo  | State Street, Cri position (Name of matory or other place)  |   | Location - City or Town, St                               | ate                                  |
| Baltimore,  | Page<br>nent c<br>ant: if<br>ury or   |                     | 1 Surial 2 ☐ Cremation 3 ☐ R  '4 ☐ Donation 5 ☐ Other (Specify)  | emoval from State  | .M. Cemetery 12/13  | /2005 Cri                                       | isfield, Mary   | land                                 |
| alt         | epartr<br>epartr<br>poort<br>y inji   |                     | 21. Signature of Funeral Services  | 2  | 2. Name and Address of Facility<br>Hinman Funeral Hom   |   |   |                                      |
| ш           | 2012  |                     | JUNEAU TILLI   | M00295   | 11673 Somerset Ave  | Princes   |   |                                      |
| ı           | Physician   |                     | shock, or heart failure. List only or mmediate Cause (Final disease or condition                               | cations that aused the death. Do not en<br>ne cause of each line.  | 0 1 1   | r respiratory arrest,<br>Sement                 | Interv  | al Between<br>a Between<br>and Death |
|             | /Medical<br>Examiner  |                     | resulting in death)  | Due to (or as a consequence of):   |   |   |   |                                      |
|             | LAGIIIIIO   | -                   | Sequentially list conditions,  | Due to (or as a consequence of):   |   |   |   |                                      |
|             | uted  | Examiner            | Cause (Disease or injury   | and the first state of the stat |   |   |   |                                      |
| o           | icate be executed<br>physician and<br>s the burial-transit  | Еха                 | that initiated events cresulting in death) Last  | Due to (or as a consequence of):   |   |   |   |                                      |
| 8760,       | ite be<br>iysicia<br>ne bur   | cal                 |  | t  |   |   |   |                                      |
| 89          | intifica<br>ing ph  | Med                 | IF FEMALE:   |  |   |   |   |                                      |
| .O. Box     | The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit  | Physician/Medical   | 23b. Was decedent pregnant in the past 12 months?  1 Yes 2 12 No 9 Unknown                                     |  | □Ectopic pregnancy<br>□ Other (specify)   |   | 23d. Date of delivery<br>Month Day                        | Year                                 |
| ۳.          | res that t<br>igned by<br>be detai  |                     | Part II. Other significant conditions con  | atributing to death but not resulting in the u   | inderlying cause given in Part I.   | 23e. Did tobacco                                | use contribute to the caus                                | e of death?                          |
| rds,        | n sign  | Completed by        | arterioschrope   | Cardiovascul   | 2 Disease   | 1 ☐ Yes   | 2 No 3 □ Probably   | 4 Unknown                            |
| Record      | sw requires been size should I  | plete               | Chronic Rena   | l Ansuddies  | enen  | 24a. Was an                                     | 24b. Were autopsy fine                                    | dings available                      |
| m m         | The fav   | mo                  | Chanic Obetni  | the Pelmona  | Diese   | autopsy<br>performed?                           | prior to completio<br>death?<br>lo 1 ☐ Yes 2 🗷 No         |                                      |
| Vital       | ician: Th<br>certificate<br>rector, pag   | Bec                 | 25. Was case referred to medical examiner?   | in acmina  | 26. Place of Death  |   |   |                                      |
| >           | Physic<br>this ce<br>al dire  | ဥ                   | 1 Yes 2 No   | lospital: 1   Inpatient 2   ER/Outpatier   |   | ne 5 Residence                                  | 6 ☐Other (Specify)  |                                      |
| 0           | ding I  | Certification:      | 27. Manner of Death  1   | 28a. Date of Injury<br>(Month, Day Year) 28b. Time o<br>Injury   |   | 8d. Describe how in                             |   |                                      |
| sion        | 9 6 0 5   |                     | 3 ☐ Suicide 6 ☐ Could not be   | 28e. Place of Injury - At home, farm, str  | reet, factory, office   | 8f. Location (Street a<br>City or Town, Sta     | and Number or Rural Route<br>te)                          | Number,                              |
| Division of |   | Certifi             | 4 Homicide determined  | building, etc. (Specify)   |   |   |   |                                      |
| Division    | Hospital or<br>4 hours afte<br>Funeral Dir<br>ely filled in   | edical Certifi      | 4 Homicide determined  29a. Certifier 1 Certifying Phys  | sician: To the best of my knowledge, deather: On the basis of examination and/or in and manner stated.   | h occurred at the time, date and place, a vestigation, in my opinion, death occurre               | nd due to the cause(<br>id at the time, date ar | s) and manner as stated.<br>nd place, and due to the ca   | use(s)                               |
| Division    | afte<br>Dir   | Medical Certifi     | 4 Homicide determined  29a. Certifier (Check only) 2 Medical Examir  | sician: To the best of my knowledge, deat<br>er: On the basis of examination and/or in   | vestigation, in my opinion, death occurre   | d at the time, date an                          | ate signed (Month, Day, Ye                                | ear)                                 |
| Division    | Hospital or<br>4 hours afte<br>Funeral Dir<br>ely filled in   | edical              | 29a. Certifier (Check only one)  Check only one)  determined  Certifying Physical Examination (Check only one) | sician: To the best of my knowledge, deat<br>er: On the basis of examination and/or in   | vestigation, in my opinion, death occurre   | d at the time, date an                          | nd place, and due to the ca                               | ear)                                 |
| Division    | Hospital or<br>4 hours afte<br>Funeral Dir<br>ely filled in   | edical              | 29a. Certifier (Check only one)  29b. Signature and title of certifier  Name and a dress of person who co      | sician: To the best of my knowledge, deat<br>er: On the basis of examination and/or in   | 29c. License number  D 29505  Print)  | 29d. D  | ate signed (Month, Day, Yo $\frac{1}{2}-09-208$           | ear)                                 |

|               |  |                   | 1 - For<br>State<br>Registrar  | State of Marylan   |  | artment of F   |  |  | giene   | 41928  |
|---------------|--|-------------------|--|--|--|--|--|--|---|--|
|               | Physici<br>/Medi   |                   | 1. Decedent's Name (First, Middle, Last,  JAMES A.   | DORSEY   |  |  |  | 2. Date of Dea<br>Month<br>Dec.                            | 7, 2005   | 3. Time of Death<br>8:25P M                        |
|               | Examir   | ner               | 4a. Facility Name (If not institution, give Beverly Health   | Care   |  | Frede  |  |  | 4c. County of Death Freder:   | ick  |
|               | Funeral<br>Director  |                   | 5. Social Security Number 6. Security Number 219-12-4842   | 7. Age (In yrs. )<br>M 2 F 95  | last birthday)<br>Yrs.                           | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.                       | 8. Date of Birth<br>(Month, Day<br>Oct. 5,                 | , Year) Cou   | place (State or Foreign<br>ntry)<br>yland          |
|               | permit. Peges 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If Item 27 is marked other than *natural', or Items 23a or 28a-f show any Injury or other treumatic event, I're Medical Examination indified at once.  | Funeral Director  | MD Frederi  10e. Street and Number  2026 Rosecrans   | ck   | Fred   | derick<br>10f. Zip Code  | 702  | 1  | log. Citizen of What Cou  | 10d. Inside City Limits                            |
| 9800          | nours after deat<br>ural', or Items ?  | by                | 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced   | 12. Was Decedent Ever in U.<br>Armed Forces?<br>1  | '  | Was Decedent of H<br>f Yes, specify Cuba<br>1 ☐ Yes 2 1 No                   | ispanic Origin? (S<br>in, Mexican, Puert<br>Specify: | pecify Yes or No-<br>o Rican, etc.)                        | 14. Race - Ameri<br>Black, White,<br>Specify: Bl                    | can Indian,<br>etc.<br>ack                         |
| 121215-0036   | iled within 72 h<br>tygiene.<br>ther then "nat<br>nt, the Medica   | Completed         | 15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0·12) 6 th  17. Father's Name (First, Middle, Last)   |  | (Give<br>life. I                                 | dent's Usual Occup<br>kind of work done of<br>DO NOT use retired<br>CK Drive | during most of wor                                   |  | Private   | dustry   |
| Maryland      | should be find Mental Find Men | To Be             | Clarke Dorse  19a. Informant's Name/Relationship (Ty   |  | 19b. Mailir                                      | ng Address (Street   | Ma   | ne (First, Middle, in a zie Taine Taine Taine Route Number |   | o Code)  |
| Baltimore, Ma | it. Peges 1 end 2 irtment of Health a irtent: If Item 27 is njury or other tre   | ,                 | Nora Dorsey- Da  20a. Method of Disposition  1 XBurial 2 Cremation 3 F  4 Donation 5 Other (Specify)  21. Signature of Funeral Service License   | emoval from State Fr   | 2026<br>lace of Dispo<br>emetery, cren<br>ciends | Rosecz<br>sition (Name of<br>natory or other place<br>ship Cem               | ans Ct   | Freder<br>Date   | ick, MD 2.<br>20c. Location - City or To<br>Damascus,<br>Funeral Ho | 1702<br>own, State                                 |
| Ba            | permi<br>Depa<br>Impo<br>any Il  |                   | 23a. Part1. Enter the disease, or complishock, or heart failure. List only or  | cations that caused the death  | 2/ 2   | 46 N. W  | ashingt  | on St  | Rockville   |  |
|               | icate be executed hybridian and Examiner sihe burial-transit   | icai Examiner     | disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last | Due to (or as a consequence of the consequence of t | uence of): LUNG                                  |  |  |  |   |  |
| BOX 6         | deeth certif<br>e ettending<br>d for use a:  | Physician/Medical | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown   | 3c. If yes, outcome of pregnar<br>1 □ Live birth 2 □ Fetal<br>4 □ Pregnant at time of de<br>9 □ Unknown  | death 3  | Ectopic pregnancy<br>Other (specify)   |  |  | 23d. Date of delive<br>Month  | ery<br>Day Year                                    |
| rds, P        | sign<br>d be   | þ                 | Part II. Other significant conditions cor<br>Coronary Art  | tributing to death but not resu<br>ery Disease   | alting in the ur                                 | nderlying cause give   | on in Part I.  |  | pacco use contribute to the   | pe cause of death?                                 |
|               |  | e Completed       | Diabetes Mel 25. Was case referred to medical  | litus  |  |  |  |  | y prior to condeath? 2 No 1 □ Yes                                   | psy findings available impletion of cause of 2 PNo |
| Ö             | d is   | To B              | examiner? 1  |  | ER/Outpatient<br>28b. Time of<br>Injury          | 28c. Injury<br>Work  | A Nursing H  |  | e)  ance 6 Other (Specify ow injury occurred                        | /)   |
| Š             | To the Hospital or Attending Ph<br>within 24 hours after death.<br>To the Funerel Director: After th<br>completely filled in by the funeral  | al Certification; | 3 Suicide 4 Homicide  6 Could not be determined  | 28e. Place of Injury - At hos building, etc. (Specify,   | )  |  |  | City or Town   |   |  |
|               | To the Hos<br>within 24 h<br>To the Fun<br>completely  | Medical           | (Check only one)  2 Medical Examir 2009. Signature and title of certifier  | ician: To the best of my knowner: On the basis of examination and manner stated.   | ion and/or inv                                   | restigation, in my op  | inion, death occur                                   | rred at the time, da                                       | ause(s) and manner as state and place, and due to                   | the cause(s)                                       |
|               | L SE O   |                   | 30. Name and address of pirson who co  | mpleted cause of death (Item   | 23a) (Type, I                                    | DOOS<br>Print) Syed 1  | 4636<br>W. Haque                                     |  | 12/8/05   |  |
|               | Sta<br>Registr   |                   | 31. Date filed (Month, Day, Year) DEC 13 20  | 10 Arc, 1<br>105 32 segistrar's Signat   | ned  | crick,   | MD   | 21701  |   |  |

|            |   | •              | For<br>State<br>Registrar   | State of Ma   |  | artment of He  |  |   | iene                                 |                               | 1929  |
|------------|---|----------------|---|---|--|--|--|---|--------------------------------------|-------------------------------|---|
|            |   | 15             | Decedent's Name (First, Middle, Last)   |   |  |  |  | 2. Date of Deat                             | h                                    | /                             | 3. Time of Death                                    |
|            | Physicia  |                | RUTH  | ANNA  | DUNN   |  |  | DEC.  | 10, 20                               | 05                            | 8:17 A M  |
|            | /Medic<br>Examin  |                | 4a. Facility Name (If not institution, give s   |   |  | 4b. City, Town, or   | Location of Death                        |   | 4c. County of                        | Death                         |   |
|            |   |                | 3403 STANFORD   | ST.   |  | HYAT   | <b>TSVILLE</b>                           |   | PRINC                                | E GE                          | ORGES   |
|            | Funeral<br>Director   |                | 5. Social Security Number 6. Sex 1 1  | 7. Age<br>M 2 □ 7. Age  | (In yrs. last birthday, Yrs.                                 | If Under 1 Year<br>Months Days                                 | If Under 24 Hrs.<br>Hours Min.           | 8. Date of Birth<br>(Month, Day,<br>FEB. 22 | Year)                                | Countr                        | nce (State or Foreign<br>y)<br>NESSEE               |
|            | p _   |                | Usual Residence of Decedent   |   | 10a City Town add  | and in a   |  |   |                                      | 10                            | d. Inside City Limits                               |
|            | arylar<br>show  | ٠.             | 10a. State 10b. County  |   | 10c. City, Town or L   | ocation  |  |   |                                      | 100                           | 1 MaYes 2 □ No                                      |
|            | 8a-1  | Director       | MD. PRINCE GE   | EORGES  |  | ADELPHI  |  | 1   | Og. Citizen of Wh                    | nat Count                     |   |
|            | with ti   | D I            | 10e. Street and Number  |   |  | 10f. Zip Code  |  | ''  | •                                    |                               | y i   |
|            | s 23g   | isai           | 3210 POWDER MI  | LL RD.  | iver in H.S. 12  |  | 20783                                    | pecify Yes or No-                           | U.S.                                 |                               | n Indian.   |
| 36         | hours after death with the Maryland<br>tural, or Items 23a or 28a-f show<br>al Examiner must be mailited at | by Funeral     | 11. Marital Status  1 Never Married 2 Married  3 XWidowed 4 Divorced  | Armed Forces?  1 Yes 2 XN If Yes, Give Year or Dates:                   | 0  | Was Decedent of His<br>If Yes, specify Cubar<br>1 ☐ Yes 2 X No | Specify:                                 | Rican, etc.)                                |                                      | White, e                      | tc.   |
| 21215-0036 | 72 hours<br>"natural",  | ed             | 15. Decedent's Educ   |   |  | dent's Usual Occupa  |  |   | 16b. Kind of Bus                     |                               |   |
| 215        | E . C .   | Completed      | (Specify only highest grade<br>Elementary/Secondary (0-12)  | College (1-4or 5  | life.  | kind of work done d<br>DO NOT use retired)                     | uring most of won                        | King  |                                      |                               |   |
| 212        | filed within "<br>Hygiene."<br>Ither than "I  | E              | 12  | Colloge (1 40) 0  | ′  | HOMEMAKE   | R  |   | НО                                   | ME                            |   |
| b          | be filed<br>tal Hygi<br>d other<br>event, I   | BeC            | 17. Father's Name (First, Middle, Last)   |   |  |  | 18. Mother's Nam                         | ne (First, Middle, M                        | Aaiden Surname,                      | )                             |   |
| <u>a</u>   | should be<br>ind Mental<br>marked o<br>umatic eve   | 일              | WILLIAM   | HOUSER  |  |  |  | MAUDE                                       | SWAG                                 | ERTT                          | Y   |
| Maryland   |   |                | 19a. Informant's Name/Relationship (Type  | oe, Print)  |  | ing Address (Street a  |  |   |                                      |                               |   |
|            | Health<br>Health<br>tem 27<br>other tra   |                | MARSHALL DUNN/S   | SON   |  | STANFORD   | ST., HY                                  |   |                                      |                               |   |
| ore        | Pages 1<br>nent of He<br>int: If Iter   |                | 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ R   | emoval from State   | 20b. Place of Disp<br>cemetery, cre                          | osition (Name of<br>imatory or other place                     | 9)                                       | Date  | 20c. Location - C                    | ity or low                    | m, State  |
| Ë          | ment<br>mant:   |                | *4 □ Donation 5 □ Other (Specify)   |   | CHAMBER  | S CREMATO  | RY   12-                                 | 13-2005_                                    | RIVERDA                              | LE,                           | MD.   |
| Baltimore, | permit. Pages Department of Important: If I any injury or once.   |                | 21. Signature of Funeral Service Ligense  | Musa  | M00091 5   | HAMBERS FI<br>801 CLEVE  | LAND AVE                                 | ., RIVERI                                   | DALE, MD                             |                               |   |
|            | Physician<br>/Medical   |                | 23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death) | DEMENTIA  | the death. Do not er<br>e.<br>A-UNSPECIF<br>consequence of): |  | g, such as cardiac                       | or respiratory arre                         | 9\$1,                                | 1 1                           | Approximate Interval Between Onset and Death  1 YR. |
|            | Examiner  penno   | Examiner       | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events             | Due to (or set  | s consequence of):   |  |  |   |                                      |                               |   |
| 68760,     | death certificate be executed e attending physician and ind for use as the burial-transit                   | dicai          | resulting in death) Last  | Due to (or as   | a consequence of):   |  |  |   |                                      |                               |   |
| .O. Box    | that the death certifica<br>ed by the attending pt<br>detached for use as th                                | Physician/Me   | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown   | 3c. If yes, outcome<br>1 ☐ Live birth<br>4 ☐ Pregnant at<br>9 ☐ Unknown | 2 Fetal death 3  | □Ectopic pregnancy □ Other (specify)                           |  |   | 23d. Date<br>Mont                    |                               | y<br>Day Year                                       |
| s, P       | es ig   | by             | Part II. Other significent conditions cor<br>HYPERTENSION,  | -   | _  |  | en in Part I.                            |   |                                      |                               | e cause of death?                                   |
| 00         | w requii  | lete           | FIBROMYALGIA,   | POT.YMYAT.G   | TA RHEIIMAT  | TCA GOUT   |  | 24a. Was a                                  |                                      | ere autop                     | sy findings available                               |
| Record     | The lav   | Completed      |   |   |  | 1011, 0001   |  | autops<br>perform                           | ned? de                              | for to com<br>eath?<br>⊒Yes 2 | pletion of cause of                                 |
| Vital      |   | e<br>C         | HYPOTHYROIDISM  25. Was case referred to medical  | , USTEUPUI  | KU515  |  | 26. Place of Dea                         | 1 ☐ Yes 2<br>ith (Check only on             |                                      |                               |   |
| of         | Phys<br>rhis<br>ral dii   | on: To B       | examiner? 1 Yes 2 XNo  27. Manner of Death 1 XNatural 5 Pending   | lospital:<br>1 ☐ Inpatie<br>28a. Date of Injui<br>(Month, Day           | y 28b. Time  | of 28c. Injury<br>Work   | ar: 4 ☐ Nursing H                        |   | ence 6 🛣 Other                       |                               | SON'S HOME  |
| Division   | or Atten<br>ifter deat<br>Sirector:<br>in by the  | Certification: | 2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined   | 28e. Place of Injubulding, etc.   | iry - At home, farm, s<br>:. (Specify)                       |  | Yes 2 □No                                | 28f. Location (St<br>City or Town           | reet and Number<br>n, State)         | r or Rural                    | Route Number,                                       |
| _          | Hospital 4 hours Funeral ely filled   | Medical Co     | 29a. Certifier 1 X Certifying Physic (Check only one) 2 Medicel Exami   | sician: To the best oner: On the basis of and manner sta                | of my knowledge, dea<br>examination and/or i                 | th occurred at the tim<br>nvestigation, in my op               | ne, date and place<br>pinion, death occu | , and due to the carred at the time, d      | ause(s) and man<br>ate and place, ar | ner as sta<br>nd due to       | ited.<br>the cause(s)                               |
|            | To the within 2 To the complet  | Mec            | 29b. Signature and title of certifiet   | 1   |  | 29c. License   | number                                   | 2   | 9d. Date signed                      | (Month, E                     | Pay, Year)  |
|            | 1   |                | <b>▶</b> ( <u>∐</u>   | Il mo   |  | D5   | 5559                                     |   | DEC. 1                               | 2. 2                          | 005   |
|            | C   |                | 30. Name and address of person who co   |   | eath (Item 23a) (Type  |  |  |   |                                      | -, -                          |   |
|            |   |                | THOMAS E. MASL  | EN, M.D.  | 7525 GF  | REENWAY CE   | NTER DR.                                 | , GREENB                                    | ELT, MD.                             | 207                           | 70  |
| \$ 1       | Sta<br>Regist   |                | 31. Date filed (Month, Day, Year) DEC 13 20   |   | ar's Signature   | partie   |  |   |                                      |                               |   |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) DECEMBER 11 **Physician** 2005 FRANCES RUTH DORSEY 3:45 РМ /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** 101 BAKER STREET ABERDEEN

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year)

Months | Days | Hours | Min. | Jan 10, 1912 ABERDEEN HARFORD 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** 1□M 2XF 92 218-05-6838 Maryland Director Usual Residence of Decedent within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location td other than "natural", or itams 23a or 28a-f show evant, the Wedled Exertetral must be notified at 1 Yes 2 No Maryland Harford Perryman rector 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ۵ 21130 USA 11 Spesutia Road 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 X Never Married 2 ☐ Married 10. Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Black à 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) <u>Licensed Prictical Nurse</u> <u> Hospital</u> and Mental Hygie 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Allen A. Dorsey Lillie J. Ringgold 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 l 15 Spesutia Road, Perryman, Maryland 21130 Dennis Dorsey / brother Baltimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or St. Paul's Lutheran 12/16/05 Aberdeen, Maryland • 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Lisa Scott Funeral Home, P.A.
552 Lewis Street, Havre de Grace, MD 21078 desa 1 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician ev -PIN LOUR /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, and be any to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner certificate be executed for use as the burial-transit Due to (or as a consequence of): ed by the attending physician detached for use as the buria Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) P.0. 9 Unknown 9 Unknown signed by t d be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, Completed by 2 No 3 Probably 4 Unknown 1 ☐ Yes peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed page 2 s this certificate has 20 No 1 ☐ Yes 2 No ours after death.

neral Diractor: After this certific filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be assisted Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 ther (Specify) 1 🗌 Yes 2 📑 No 2 ER/Outpatient 3 DOA Medical Certification: To 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 Natural 5 Pending Injury Division 1 ☐ Yes 2 ☐ No investigation 2 ☐ Accident 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 - Homicide ŏ within 24 hours a To the Funeral C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed, (Month, Day, Year) 29b. Signature and title prestifie 29c. License number 30. Name and address of person who pompleted cause of death (Item 23a) (Type, Print) anne 31. Date filed (Month, Day, Year) 32. Registrar's Signatur State Registrar

|   |   |  | 1 - For<br>State<br>Registrar  | State of Maryland  | / Department of<br>Certificate   |  |  | iene<br>g. Ng 2 1 1 1 5   | 11031   |
|---|---|--|--|--|--|--|--|---|---|
| 10 mg/s/s/s/s/s/s/s/s/s/s/s/s/s/s/s/s/s/s/s | Physici   | an   | 1. Decedent's Name (First, Middle, Last  | 0  |  |  | 2. Date of Death   | Day Year  | 3. Time of Death  |
|   | Physici<br>/Medic   |  | CHESTER ANDREW   | DeCESARIS  | ***************************************  |  | December   |   | 8:55 A <sup>M</sup>   |
|   | Examir  | er   | 4a. Facility Name (If not institution, give  | ·  |  | wn, or Location of Death   |  | 4c. County of Death   |   |
| - 1<br>- 2                                  | Funcial   |  | Montgomery General Security Number 6. Se   |  | 01ne   |  | 8 Date of Birth  | Montgomer   | y<br>place (State or Foreign  |
| À   | Funeral Director  |  |  | XM 2□F 76  | Yrs. Months D  | ays Hours Min.   | 8. Date of Birth (Month, Day, Dec. 10  |   | rick, PA  |
|   | pu ,  |  | Usual Residence of Decedent  10a. State 10b. County  |  | Town or Location   |  |  |   |   |
|   | laryla<br>ahov  | or   |  |  |  |  |  | 1   | 1  Yes 2 No   |
|   | 28a-i   | Directo  | Maryland Montgome  10e. Street and Number  | era 211  | Lver Spring  | de   | 10   | g. Citizen of What Cour   |   |
|   | 3a or   | io I   | 204 Rosalie Cove   | Court  | 209  |  |  | U.S.A.  | idy:  |
|   | death   | Funeral  | 11. Marital Status   | 12. Was Decedent Ever in U.S.  | 13. Was Decedent   | of Hispanic Origin? (Sp.<br>Cuban, Mexican, Puerto   | ecify Yes or No-   | 14. Race - Americ   |   |
| 92  | or Ite  |  | 1 Never Married 2 Married  | 1 文 Yes 2 No to  | _  | No Specify:  | rican, etc.)   | Black, White, Specify: Whit   |   |
| Ö   | 72 hours after death with the Maryland<br>natural', or Iteme 23s or 28s-1 show<br>deal Evanance must be notified at   | d by   | 3 ☑ Widowed 4 □ Divorced   | Year or Dates 1967   |  |  |  |   |   |
| 5   | in 72<br>in " n   | Completed                                      | 15. Decedent's Edu<br>(Specify only highest grad   | de completed)  | 16a. Decedent's Usual O<br>(Give kind of work d<br>life. DO NOT use n  | ccupation<br>lone during most of work.<br>etired)  | ng   | 6b. Kind of Business/Ind<br>United Stat   | *   |
| 212   | filed within<br>Hygiene.<br>ther than "   | шо   | Elementary/Secondary (0-12)<br>12th  | College (1-4or 5+)   | Accounta   |  |  | Government  | es  |
| ng  | 0 = 0 5   | Bec  | 17. Father's Name (First, Middle, Last)  |  |  | 18. Mother's Name  | (First, Middle, M  | laiden Sumame)  |   |
| Z   | should bund Ment  | To   | Rinaldo Vincenz  |  |  | Yolanda  |  | oldy  |   |
| Maryland 21215-0036                         | 12 sh<br>h and<br>7 Is m<br>rreum   |  | 19a. Informant's Name/Relationship (T)   |  | 19b. Mailing Address (St   |  |  |   |   |
|   | 1 and<br>Health<br>em 27  |  | Chester A. DeCesa 20a. Method of Disposition   | 20b. Plac  | 204 Rosalie ce of Disposition (Name of   | of I   |  | Spring, MD  Oc. Location · City or To   |   |
| <u>o</u> E                                  | Pages<br>ment of<br>ant: If It  |  | 1 ☐ Burial 2 ☑ Cremation 3 ☐ F<br>4 ☐ Donation 5 ☐ Other (Specify)   | Removal from State   | netery, crematory or other<br>incoln Crema   | r place)   |  | Brentwood, M  |   |
| Baltimore,                                  | _ + + + + + + + + + + + + + + + + + + +   | - 1  | 21. Signature of Funeral Service Licens  |  | 7.000  |  |  |   | aryrand   |
| ñ   | Depared Important Information |  | Nancy A. X   | Versen Va  | HINES-RII  | ddress of Facility<br>NALDI FUNER<br>w Hampshire   | AL HOME,   | INC.<br>1ver Spring   | MD 2090/  |
|   | Physician   |  | 23a. Part1. Enter the disease, or compleshock, or bean failure. List only of   | lications that caused the death.   | Do not enter the mode of   | dying, such as cardiac   | or respiratory arre  | st,   | Approximate<br>Interval Between   |
|   |   |  | Immediate Cause (Final disease or condition  | a Kesperat   | ory to   | love   |  |   | Onset and Death   |
|   | /Medical<br>Examiner  |  | resulting in death)  | Due to (or as a conseque   |  | 0.   |  |   | -242  |
| w.  |   | er   | Sequentially list conditions,  | b. Due to (or as a conseque  | Ohoff wet  | rue tol  | maran  | · Pisece  | years   |
|   | uted<br>d<br>ansit  | Examin   | if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events  | (0. 00 00 00 00 00 00 00 00 00 00 00 00 0  |  |  |  | 2   | 3   |
| o   | be executed<br>sician end<br>burial-transit   | Exa  | resulting in death) Last   | Due to (or as a consequer  | nce of):   |  |  |   |   |
| 3/60  | ate be executed<br>hysician end<br>the burial-transit   | dical  |  | d  |  |  |  |   |   |
| Õ   | ertifica<br>ling ph<br>e as t   |  |  | u  |  |  |  |   |   |
|   |   |  | IF FEMALE:   |  |  |  |  |   |   |
| O<br>H                                      | atten<br>for u  |  | IF FEMALE: 23b. Was decedent pregnant in the past 12 months?   | 23c. If yes, outcome of pregnanc   | eath 3 Ectopic pregn   |  |  | 23d. Date of delive   | ,   |
| O. Box                                      | the death certific<br>the attending p<br>ched for use as  |  | 23b. Was decedent pregnant   | 23c. If yes, outcome of pregnanc<br>1 □ Live birth 2 □ Fetal do<br>4 □ Pregnant at time of deat<br>9 □ Unknown   | eath 3 Ectopic pregn   |  |  |   | ry<br>Day Year  |
| л<br>О                                      | s that the death or<br>ned by the atten<br>edetached for us   | Physician/Me                                   | 23b. Was decedent pregnant in the past 12 months?  | 1 ☐Live birth 2 ☐ Fetal de<br>4 ☐ Pregnant at time of deal<br>9 ☐ Unknown  | eath 3 □Ectopic pregn<br>th 5 □ Other (specifi   | y)   | 23e. Did toba  |   | Day Year  |
| л<br>О                                      | quires that the death on signed by the attenuid be detached for u   | by Physician/Me                                | 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown   | 1 Live birth 2 ☐ Fetal de 4 ☐ Pregnant at time of deal 9 ☐ Unknown  ntributing to death but not resulti  | eath 3 □Ectopic pregn<br>th 5 □ Other (specifi   | y)   | 23e. Did toba  | Month acco use contribute to the  | Day Year  |
| л<br>О                                      | aw requires that the death one is been signed by the attental should be detached for u  | by Physician/Me                                | 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown  Part II. Other significant conditions con   | 1 Live birth 2 ☐ Fetal de 4 ☐ Pregnant at time of deal 9 ☐ Unknown  ntributing to death but not resulti  | eath 3 □Ectopic pregn<br>th 5 □ Other (specifi   | y)   | 1 Yes  | Month  acco use contribute to the 2 No 3 Probe  | Day Year  le cause of death?  ably 4 Unknown  osy findings available  |
| л<br>О                                      | The law requires that the date has been signed by the page 2 should be detached   | by Physician/Me                                | 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown  Part II. Other significant conditions con   | 1 Live birth 2 ☐ Fetal de 4 ☐ Pregnant at time of deal 9 ☐ Unknown  ntributing to death but not resulti  | eath 3 □Ectopic pregn<br>th 5 □ Other (specifi   | y)   | 1 Yes<br>24a. Was an<br>autopsy<br>perform   | Month  acco use contribute to the 2 No 3 Probi  | Day Year  le cause of death?  ably 4 Unknown  by findings available inpletion of cause of   |
| л<br>О                                      |   | Physician/Me                                   | 23b. Was decedent pregnant in the past 12 months? 1   Yes 2   No 9   Unknown  Part II. Other significant conditions con  | 1 □ Live birth 2 □ Fetal de 4 □ Pregnant at time of deat 9 □ Unknown  ntributing to death but not resulti  | eath 3 □Ectopic pregn<br>th 5 □ Other (specifi   | e given in Part I.  26. Place of Death   | 24a. Was an autopsy perform  | Month  acco use contribute to the 2 No 3 Probi  | Day Year  le cause of death?  ably 4 Unknown  |
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| of Vital Records, P.O.                      | or Attending Physicien:<br>after death.<br>Director: After this certifica<br>in by the funeral director, p.   | Certification; To Be Completed by Physiclan/Me | 23b. Was decedent pregnant in the past 12 months?  1   Yes 2   No 9   Unknown  Part II. Other significant conditions cond | al □Live birth 2 □ Fetal de 4 □ Pregnant at time of deal 9 □ Unknown  Intributing to death but not resulting to death but not resulting to death but not resulting to death but not resulting to death but not resulting leading.  28a. Date of Injury 2 2 □ EF □ 28a. Date of Injury 2 at home building, etc. (Specify)  28e. Place of Injury - At home building, etc. (Specify)  sician: To the best of my knowle nar: On the basis of examination and manner stated.  | ath 3 Ectopic pregnth 5 Other (specify 5 Other (specify 5) Other ( | 26. Place of Death  26. Place of Death  Other: 4 \sum Nursing Hor  Injury at Work?  1 \sum Yes 2 \sum No  ice ::  te time, date and place, any opinion, death occurrence in the control of | 24a. Was an autopsy perform 1 Yes 2  (Check only one me 5 Resider 28d. Describe how City or Town, and due to the cate and at the time, dat | Month  acco use contribute to the contribute to | Day Year  The cause of death? |
| of Vital Records, P.O.                      | Hospital or Attending Physicien:<br>4 hours after death.<br>Funeral Director: Atter this certifica<br>ely filled in by the funeral director. F  | Certification; To Be Completed by Physiclan/Me | 23b. Was decedent pregnant in the past 12 months?  1   Yes   2   No   9   Unknown  Part II. Other significant conditions  | al □Live birth 2 □ Fetal de 4 □ Pregnant at time of deal 9 □ Unknown  Intributing to death but not resulting to death but not resulting to death but not resulting to death but not resulting to death but not resulting leading.  28a. Date of Injury 2 2 □ EF □ 28a. Date of Injury 2 at home building, etc. (Specify)  28e. Place of Injury - At home building, etc. (Specify)  sician: To the best of my knowle nar: On the basis of examination and manner stated.  | ath 3 Ectopic pregnth 5 Other (specify 5 Other (specify 5) Other ( | 26. Place of Death  26. Place of Death  Other: 4 \sum Nursing Hor  Injury at Work?  1 \sum Yes 2 \sum No  ice ::  te time, date and place, any opinion, death occurrence in the control of | 24a. Was an autopsy perform 1 Yes 2  (Check only one me 5 Resider 28d. Describe how City or Town, and due to the cate and at the time, dat | Month  acco use contribute to the contribute to | Day Year  The cause of death? |
| of Vital Records, P.O.                      | Hospital or Attending Physicien:<br>4 hours after death.<br>Funeral Director: Atter this certifica<br>ely filled in by the funeral director. F  | Certification; To Be Completed by Physiclan/Me | 23b. Was decedent pregnant in the past 12 months?  1   Yes   2   No   9   Unknown  Part II. Other significant conditions  | al □Live birth 2 □ Fetal de 4 □ Pregnant at time of deal 9 □ Unknown  Intributing to death but not resulting to death but not resulting to death but not resulting to death but not resulting to death but not resulting leading.  28a. Date of Injury 2 2 □ EF □ 28a. Date of Injury 2 at home building, etc. (Specify)  28e. Place of Injury - At home building, etc. (Specify)  sician: To the best of my knowle nar: On the basis of examination and manner stated.  | ath 3   Ectopic pregnth   3   Other (specify   S    | 26. Place of Death  26. Place of Death  Other: 4 \sum Nursing Hor  Injury at Work?  1 \sum Yes 2 \sum No  ice ::  te time, date and place, any opinion, death occurrence in the control of | 24a. Was an autopsy perform 1 Yes 2  (Check only one me 5 Resider 28d. Describe how City or Town, and due to the cate and at the time, dat | Month  acco use contribute to the contribute to | Day Year  The cause of death? |

|                                |  |                          | 1 - For<br>State<br>Registrar  | State of N   | laryland / Dep<br>Co                   | ertificate of l                                     |   |   | 005   | 41932   |
|--------------------------------|--|--------------------------|--|--|--|---|---|---|---|---|
|                                | Physici  | an                       | 1. Decedent's Name (First, Midd  |  |  |   |   | 2. Date of Death<br>Month<br>DECEMBER           | <sup>Day</sup> , 2005                         | 3. Time of Death 11:45 AM                         |
|                                | /Medic<br>Examin   |                          | Gail S. De   | ,  |  |   | 4c. County of Death   | 1   |   |   |
|                                | Cxamii   | ICI                      | 5200 WESTPORT  |  | CHASE                                  |   | MONTGOME  |   |   |   |
|                                | Funeral<br>Director  |                          | 5. Social Security Number 215-54-5384  | 6. Sex 7. A  | Age (In yrs. last birthda<br>59 Yrs.   | /) If Under 1 Year<br>Months Days                   | Hours Min.  | 8. Date of Birth<br>(Month, Day, Y<br>May 31,19 |   | pplace (State or Foreign<br>intry)<br>Chington DC |
|                                | fand<br>w  |                          | Usual Residence of Decedent  10a. State 10b. County  | /  | 10c. City, Town or                     | ocation   |   |   |   | 10d. Inside City Limits                           |
|                                | Mary<br>B-f ah   | tor                      | MD Mont  | gomery   | Chevy (                                | lhase   |   |   |   | 1 ☐ Yes 2 ☐ No                                    |
|                                | or 28  | Olrec                    | 10e. Street and Number   |  |  | 10f. Zip Code                                       |   | 10g   | . Citizen of What Co                          | intry?  |
|                                | eth w  | rall                     | 5200 Westpor   |  |  | 208   |   |   | nited Stat                                    |   |
| 900                            | permit. Pages 1 end 2 should be tiled within 72 hours efter deeth with the Maryland Department of Heetth and Mental Hygiene. Important: if item 27 is marked other than "natural", or Items 23a or 28a-f ahow any injury or other traumatic avant, the Medical Examitrier must be motified at once.  | by Funeral Director      | 11. Marital Status  X☐ Never Married 2☐ Mai 3 ☐ Widowed 4 ☐ Divorces   | If Yes Give  | 5?<br><b>X</b> No                      | . Was Decedent of H If Yes, specify Cub  1 Yes 2 No | dispanic Origin? (Spec<br>an, Mexican, Puerto F<br>Specify: | offy Yes or No-<br>lican, etc.)                 | 14. Race - Amer<br>Black, White<br>Specify: W |   |
| 2-0                            | 72 ho  | etec                     |  | nt's Education<br>est grade completed)                 | (Giv                                   | edent's Usual Occup<br>e kind of work done          | during most of workin                                       | g 16  | b. Kind of Business/l                         | ndustry   |
| 12                             | within<br>9ne.<br>then   | Completed                | Elementary/Secondary (0-12)  | College (1-4o  | lite                                   | DO NOT use retire                                   | d)  |   | T   |   |
| Baltimore, Maryland 21215-0036 | Hygi<br>Hygi<br>other  | To Be Co                 | 17. Father's Name (First, Middle,  | , Last)  |  | Clerk   | 18. Mother's Name   | (First, Middle, Ma                              | <u>Insurance</u><br>iden Sumame)              |   |
|                                | uld be<br>Venta<br>vrikad<br>rtic av   |                          | Chales Melvi   | n Delozier   |  |   | Jean (  | Coffman   |   |   |
| lan                            | and t  |                          | 19a. Informant's Name/Relations  |  | 1                                      | -   | and Number or Rural   |   | •   | p Code)   |
| e)                             | 1 end<br>1 eelth<br>1 m 27<br>Der tr   |                          | Campbell Graeu  20a. Method of Disposition   | b/Personal B   | Rep 520                                |   | t Rd.,Chev  |   |   |   |
| nor                            | age of the state o |                          | 1 ☐ Burial 2 ☐ Cremation   |  | e cemetery, cr                         | ematory or other pla                                | cө)   |   | c. Location - City or 1                       |   |
| Ħ                              | nit. P<br>artme<br>ortan<br>injuri   |                          | 4 □ Donation 5 □ Other (S<br>21. Signature of Fureral Service  |  |  | .1 Cremato 22. Name and Addre                       | ry   12-11  |   | Falls Chur                                    |   |
| ä                              | Ded of the same  |                          | - Adular   | - Bush   |  |   | nsin Ave,N  |   |   |   |
|                                |  |                          | 23a. Part1. Enter the disease, o<br>shock, or heart failure. Lis   | r complications that cause<br>t only one cause on each | ed the death. Do not e line.           | nter the mode of dyir                               | ng, such as cardiac or                                      | respiratory arrest                              |   | Approximate<br>Interval Between                   |
|                                | Physician<br>/Medical<br>Examiner  | Examiner                 | Immediate Cause (Final disease or condition resulting in death)  | Due to (or a   | roscleros a consequence of):           | stic G  | rdivasa   | der dis   | sease   | Onset and Death                                   |
|                                | pe tis   |                          | Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury   |  | s a consequence of):                   |   |   |   |   |   |
|                                | and<br>I-trans   |                          | that initiated events resulting in death) Last   | c. Due to (or a  | s a consequence of):                   |   |   |   |   |   |
| 68760,                         | ificate be executed<br>g physicien and<br>as the burial-transit  | alE                      |  |  |  |   |   |   |   |   |
| 89                             | tificate be executed<br>g physicien and<br>as the burial-transit   | edical                   |  | G  |  |   |   |   |   |   |
| P.O. Box                       | Attanding Physician: The law requires thet the death cent robath: The death actor: After this certificete hes been signed by the ettending the funeral director, page 2 should be detached for use   | nysician/M               | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown  |  | 2 Fetal death 3                        | ☐Ectopic pregnancy<br>☐ Other (specify) _           | ,   |   | 23d. Date of deliv<br>Month                   | rery<br>Day Year                                  |
| S,                             | gned to  | эу Р                     | Part II. Other significant conditi   | ons contributing to death                              | but not resulting in the               | underlying cause giv                                | en in Part I.   | 23e. Did tobac                                  | co use contribute to                          | the cause of death?                               |
| ord                            | equire<br>sen sig<br>ould b  | Completed by Physician/M | cerebral   | pasy   |  |   |   | 1 🗆 Yes   | 2 □ No 3 □ Pro                                | bably 4\(\notine{U}\)Unknown                      |
| ec                             | law r  |                          |  |  |  |   |   | 24a. Was an autopsy                             | prior to co                                   | opsy findings available ompletion of cause of     |
| 回田                             | r: The   |                          |  |  |  | _   |   | performer<br>12 Yes 2                           |   | 2 □ No  |
| <u> </u>                       | sician<br>certif<br>irector  | Be c                     | 25. Was case referred to medica examiner? 1 X Yes 2 No   | Hospital:  |  | ont 3CIDOA Oth                                      | 26. Place of Death  |   |   | CCENE   |
| ō                              | Physical dispersion  | 7: To                    | 27. Manner of Death  | 28a. Date of In  |  | AIR SEL DON   | 4 Inursing Hom  | e 5 Residence  Bd. Describe how                 | e 6 NOther (Speci                             | SCENE SCENE                                       |
| ion                            | ittending<br>death.<br>ctor; Aft   | atlo                     | C  | ng (Month, D<br>gation                                 | a <i>y Year)</i> Injury                |   | k?<br>Yes 2 ☐ No  |   |   |   |
| Division of Vital Records,     | i or Atta<br>efter de<br>Diracto<br>I in by th   | Certification:           | 3 ☐ Suicide 6 ☐ Could<br>4 ☐ Homicide determ   | nined   286. Place of Ir                               | njury - At home, farm, setc. (Specify) | treet, factory, office                              | 28  | 3f. Location (Stree<br>City or Town, S          | et and Number or Rur<br>State)                | al Route Number,                                  |
|                                | pital c  |                          |  |  |  |   |   |   |   |   |
|                                | To the Hospital or Attanding Physicien: The law requires the within 24 hours elter death. To the Funeral Director: After this certificate hes been signed completely filled in by the funeral director, page 2 should be de  | edical                   | 29a. Certifier  (Check only one)  Check only one  Check o |  |  |   |   |   |   |   |
| )                              | To the complet   | Me                       | 29b. Signature and title of certifie   | umica-   | 200 emo                                | 29c. Licens   | e number<br>CME   | 29d.  | Date signed (Month, CEMBER 6,                 | Day, Year)<br>2005                                |
|                                | _  |                          | 30 Name and address of person  | who completed cause of                                 | death (Item 23a) (Type                 | Print)<br>111 PENN                                  | STREET, BA  | LTIMORE,  | MARYLAND,                                     | 21201   |
|                                | Sta  |                          | 31. Date filed (Month, Day, Year, DEC 12   | 2005 39. Regist  | trar's Signature                       |   |   |   |   |   |
|                                | Registr  | ell<br>Not               | DEC 1 %  | 2005 France  | J. J. Jagan                            |   |   |   |   |   |

|                     |  | •              | State Amend Item#5 per   | ate of Maryland / De<br>FH G852 2/28/   | epartment of Health and<br>Office the of Death  | Mental Hygien  | 2005 41933  |
|---------------------|--|----------------|--|---|---|--|---|
|                     | Dhysioi  | an             | 1. Decedent's Name (First, Middle, Last)   |   |   | 2. Date of Death<br>Month Da                             | 3. Time of Death  |
|                     | Physicia<br>/Medic   |                | Mary Gertr   |   | th City Taylor and and the City   | Dec 17, 200  |   |
|                     | Examin   | er             | 4a. Facility Name (If not institution, give street<br>Cumberland Nursing C   |   | 4b. City, Town, or Location of Dea  |  | c. County of Death<br>.llegany  |
|                     | Funeral  |                | 5. Social Security In Tipo 6. Sex  | 7. Age (In yrs. last birtho   |   | s. 8. Date of Birth                                      | 9. Birthplace (State or Foreign   |
|                     | Director   |                | 219-03-8563  | ₩ 90 Yr   | 5.  | Aug 19, 19   | 15 MD   |
|                     | yland<br>now   |                | 10a. State 10b. County   | 10c. City, Town o   |   |  | 10d. Inside City Limits   |
|                     | e Mar  | Director       | WV' Mineral  | Rid   | geley   |  | 1 □ Yes 2 □ No  |
|                     | with th  |                | 10e. Street and Number   |   | 10f. Zip Code 26753   | 10g. C   | itizen of What Country? USA   |
|                     | death  | Funerai        | 4 Motel Road  11. Marital Status   | as Decedent Ever in U.S.  | 13. Was Decedent of Hispanic Origin? (  | Specify Yes or No-                                       | 14. Race - American Indian,   |
| 98                  | 72 hours after death with the Maryland<br>'natural', or items 23a or 28a-f show<br>Sical Exactions from the profifted at | / Fur          | 1 Never Married 2 Married 1  | med Forces?  Yes 2√No Yes, Give   | If Yes, specify Cuban, Mexican, Puè  1 Yes 2 No Specify:                              | rto Hican, etc.)   | Black, White, etc.  |
| Ö                   | 72 hours<br>natural',<br>ilcel Exe   | ed by          | 3 XWidowed 4 □ Divorced Ÿ.   | ear or Dates:   | ecedent's Usual Occupation  | 166 6  | Specify: white Kind of Business/Industry                                    |
| 215                 | C *_ 38  | Completed      | (Specify only highest grade com  | pleted) (()<br>bilege (1-4or 5+)  | Give kind of work done during most of wo<br>fe. DO NOT use retired)                   | orking   | and of Daomood modelity   |
| 21                  | ien i  | Con            | 12   | Secr  |   |  | ctrical Union, Inc.   |
| Maryland 21215-0036 | ed ala   | o Be           | 17. Father's Name (First, Middle, Last)  Earl Leo Powell   |   |   | <sub>ame (First, Middle, Maide)</sub><br>ca Flizabeth    | (Beal) Powell   |
| aryl                | de E   | ř              | 19a. Informant's Name/Relationship (Type, P  |   | failing Address (Street and Number or F   | Rural Route Number, City                                 | or Town, State, Zip Code)   |
|                     | 1 and 2<br>Health a<br>tem 27 is   |                | Bonnie Atkinson  |   | 301 McMullen Hwy.   | Cumberla   |   |
| Baltimore,          | Pages 1 ar   |                | 20a. Method of Disposition 1   Burial 2 □ Cremation 3 □ Remov  |   | isposition (Name of<br>crematory or other place)<br>Nemorial Park                     | 12/21/2005 CU  | ocation - City or Town, State  Imberland MD                                 |
| Itim                |  |                | ' 4 □ Donation 5 □ Other (Specify)  21. Signature F neral Service Licensee   | A / / ·   |   |  | imberiand MD  |
| Ba                  | permit. Departr Importa  |                | 1/1/W/n/ 7   | hull  | 22. Name and Address of Facility Scarpelli Funeral F 108 Virginia Avenu               |  | MD 21502  |
|                     |  |                | 23a. Party. Enfer the disease, or complication shock, or heart failure. List only one call   | s that caused the death. Do not se on each line.                                  | enter the mode of dying, such as cardia   | ac or respiratory arrest,                                | Approximate<br>Interval Between   |
|                     | Pnysician<br>/Medical  |                | Immediate Cause (Final disease or condition resulting in death)  | Inohable Co   | vonany antery d   | reare  | Onset and Death   |
| Н                   | Examiner   |                |  | Due to (or as a consequence of)   | 1 %   |  | /   |
|                     | p =  | ner            | Sequentially list conditions, the style of t | Dualto (or as a nonsequence of)   |   |  |   |
| H                   | cate be executed<br>physician and<br>s the burial-transit  | Examine        | Cause (Disease or injury that initiated events c c   | Due to (or as a consequence of)   |   |  |   |
| 68760,              | sician<br>buria  | dicai E        | d  | 220 10 (01 20 2 0011004201100 01)   | •   |  |   |
|                     |  | Medic          | ISSENIA S  |   |   |  |   |
| Box                 | death certifi<br>e attending I<br>od for use as  | Physician/Me   | in the past 12 months?   | yes, outcome of pregnancy<br>Live birth 2 Petal death                             | 3 Ectopic pregnancy   |  | 23d. Date of delivery  Month Day Year                                       |
| 0                   | 0 0  | ysic           | 1 Yes 2 No   | □Pregnant at time of death<br>□Unknown  | 5 Other (specify)   |  | ,   |
| S, P                | The law requires that the ste has been signed by the bage 2 should be detache  | by Pr          | Part II. Other significant conditions contribut  | ing to death but not resulting in th  | ne underlying cause given in Part I.  | 23e. Did tobacco   | use contribute to the cause of death?                                       |
| ord                 | v require<br>been sig<br>should b  |                |  |   |   | 1 ☐ Yes 3  | No 3 Probably 4 □Unknown  |
| Record              | ne law r<br>s has be<br>ge 2 sh  | Completed      |  |   |   | 24a. Was an autopsy performed?                           | 24b. Were aulopsy findings available prior to completion of cause of death? |
| alF                 |  | e Cor          | 25. Was case referred to medical   |   | 00 Plant 1 P  | 1 Tes 2 No   | 1 Yes 2 No  |
| Vital               | Physician:<br>this certific<br>ral director,   | 0 8            | examiner?  1 Yes 2 No Hospit   | al: 1  Inpatient 2 ER/Outp  |   | Home 5 Residence   | 6 □Other (Specify)  |
| n of                | ng<br>ftei<br>ne   | Du: T          | 27. Manner of Death 1. Natural 5 Pending   | a. Date of Injury<br>(Month, Day Year) 28b. Tin                                   | ne of 28c. Injury at  | 28d. Describe how inju                                   |   |
| Division            | Attending<br>ar death.<br>ector: Atter<br>by the fune  | icati          | 2 Accident investigation 3 Suicide 6 Could not be  | Diago of Injury At home form  | M 1 Yes 2 No  | 28f Logation (Street a                                   | and Alumbas as Dural Pauta Alumbas  |
| N<br>O              | 2 # = -  | Certification: | 4 Homicide determined 28   | <ul> <li>Place of Injury - At home, farm building, etc. (Specify)</li> </ul>      | , street, radory, onice   | City or Town, Stat                                       | nd Number or Rural Route Number,<br>e)                                      |
|                     | Hospit<br>24 hour<br>Funera<br>tely fille  | edical C       | (Check only 2 Nedical Examiner: (  | : To the best of my knowledge, on the basis of examination and/ond manner stated. | death occurred at the time, date and place or investigation, in my opinion, death occ | e, and due to the cause(s<br>curred at the time, date an | s) and manner as stated.<br>Id place, and due to the cause(s)               |
|                     | To the within 2 To the comple  | Me             | 29b. Signature and title of certifie   | Λ   | 29c. License number   |  | ate signed (Month, Day, Year)   |
| •                   |  |                | - Lyn  | e Kra   | 00033280  |  | e 20,2005   |
|                     | 6  |                | 30. Name and address of person and comple  | ed cause of death (Item 23a) (Ty  | rpe, Print)   |  | 1500  |
|                     | Sta  |                | Sunil Gupta V.M.D.   | 32 Aegistrar's Signature  | Kent Avenue Cumb  | eriano IVID 21   | 1002  |
|                     | Registr  | ar             | DEC 2 7 2005   | Barnes 10° 1  |   |  |   |

|  |  | 1 - State<br>Registrar   |  | aryland / Depa<br><i>Cei</i>  | rtificate of   |  | , ,  | Neg(No.)   | 5 4  | 1934  |
|--|--|--|--|---|--|--|--|--|--|---|
| Physici<br>/Medic  | an<br>cal                                | Decedent's Name (First, Middle, La      MARY ELLEN FREDE      4a. Facility Name (If not institution, giv   | ERICK  |   | 4. Ch. T.  |  | 2. Date of Dea<br>Month<br>DECEMB  | ER 12  | 2005   | 3. Time of Dea 7:30AN   |
| Examir   | ICI                                      | 6 CHADWICK TERRA  5. Social Security Number 6. S   | CE   | e (In yrs. last birthday)   | 4b. City, Town, o  | TON  |  | 4c. County   | ВОТ  | (Chair on Fou   |
| Funeral<br>Director  |  |  | 1 □ M 2 □ <b>X</b> F   | 84 Yrs.   | Months Days  |  |  | 921 <sup>(1)</sup>   | KANS   | AS (State or For  |
| ure!, or items 23a or 28e-f show<br>al Examinat must be notified at  | ctor                                     | MD 10b. County TALE  | зот  | 10c. City, Town or Lo   |  |  |  |  | 10   | d. Inside City Lir  |
| 3a or 28   | a Director                               | 10e. Street and Number  6 CHADWICK TERRA   | CE   |   | 10f. Zip Code <b>216</b>                                     | 01   | 1  | 10g. Citizen of V  | What Count   | •   |
| irel', or items 23a or 28e-f show<br>Examiner must be notified at  | d by Funerai                             | 11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 🛣 Widowed 4 ☐ Divorced  | 12. Was Decedent B<br>Armed Forces?<br>1 □ Yes 2 2. If Yes, Give<br>Year or Dates:   | No  | Was Decedent of H<br>If Yes, specify Cub<br>1 ☐ Yes 2 📉 No   | an, Mexican, Pu  | (Specify Yes or No-<br>erto Rican, etc.)   | Blad   | ce - America<br>ck, White, e   | tc.   |
| iene.<br>rthan "naturel",<br>the Medical Ex  | Completed                                | 15. Decedent's Ed<br>(Specify only highest gra<br>Elementary/Secondary (0-12)  | ducation<br>ade completed)  College (1-4or 5   | (Give<br>life.  | dent's Usual Occup<br>kind of work done<br>DO NOT use retire | during most of w<br>d)   | rorking  | OWN H  |  | ustry   |
| I health and Mental Hygitem 27 is marked other other treumetic event,  | To Be C                                  | 17. Father's Name (First, Middle, Last, HOMER RICHTER  | )  |   |  | 18. Mother's N   | ame (First, Middle, LE OLIPHAN   | Maiden Sumam   |  |   |
| Department of Important: If it it it it it it it it it it it it it   |  | 1 Burial 2 Cremation 3 4 Donation 5 Other (Specification 5) Other (Specificati | nsee  Struck conplications that caused   | F.S.P. FE 20  | Name and Addre<br>LLOWS, H<br>OS. HAR<br>er the mode of dyi  | ess of Facility ELFENBE RISON S' ng, such as card  | N & NEWNA<br>EASTON,<br>ac or respiratory arm  | M FUNE<br>MD 2160<br>est,  | RAL HO   | DME PA  Approximate Interval Between Conset and Deal Conset and Deal Conset and Deal Conset and Deal Conset and Deal Conset and Deal Conset and Deal Conset and Deal Conset and Deal Conset and Deal Conset and Deal Conset   |
| cian and purial-transit  | dical Examiner                           | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last   | b. Meta Due to (or as a C. Uppe  | a consequence of):  Statio a consequence of):  a consequence of):   | Liver<br>BS  | Dis.   | Blad<br>pasell   |  | 1-2  | wee   |
| ÷ =  | 0 -                                      | IF FEMALE:   | 23c. If yes, outcome   |   |  |  |  | 23d. Dat   | te of deliver  |   |
| attending<br>for use as  | nysicia                                  | 23b. Was decedent pregnant in the past 12 months? 1 □Yes 2 □No 9 □Unknown  | 1 □ Live birth 4 □ Pregnant at 9 □ Unknown   |   | Ectopic pregnancy<br>Other (specify)                         |  |  | Мог  |  | •   |
| igned by the attending<br>be detached for use as   | 0  | in the past 12 months?<br>1 □ Yes 2 □ No   | 4□Pregnant at<br>9□ Unknown  | time of death 5   | Other (specify)  |  | 23e. Did tot   | bacco use contr  | nth E  | Day Year  |
| ate has been signed by the attending<br>page 2 should be detached for use a  | Completed by                             | in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  Part II. Other significant conditions of  | 4□Pregnant at<br>9□ Unknown  | time of death 5   | Other (specify)  | ren in Part I.   | 1 Yes 2  | pacco use control of the control of  | nth E  | cause of death bity 4 Unkn sy findings avai   |
| this certificate has been signed by the attending at director, page 2 should be detached for use as  | To Be Completed by                       | in the past 12 morths?  1  | Hospital:  28a. Date of Injur (Month, Day)   | time of death 5 Lat not resulting in the un   | t 3 DOA  | zen in Part I.  26. Place of D  ier: 4 \subseteq Nursing   | 1 Ye   | mod? 2 DNo 1 24b. Vined? 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1   | ribute to the  3 Probal  Were autops orior to compleath?  Yes 2  er (Specify)                        | cause of death bity 4 Unkn sy findings avai   |
| this certificate has been signed by the attending at director, page 2 should be detached for use as  | o Be Completed by                        | in the past 12 morths?  1  | Hospital: 1 Inpatier 28a. Date of Injur (Month, Day)   | nt 2 ER/Outpatien  Year)  ER/Outpatien  Year 2 SB. Time of Injury   | t 3 DOA  28c. Injur M  1                                     | zen in Part I.  26. Place of D ier: 4 □ Nursing y at k?  | 24a. Was a autops perform 1 Yes 2 eath Check onl on  | mod? 24b. Vined? 2 No 1 24b. Vined? 2 No 1 24c. Vined? 2 No 1 24c. Vined? 2 No 1 24c. Vined? 2 No 1 24c. Vined? 2 No 1 24c. Vined? 24c. Vi | nibute to the  3 Probal  Were autops grior to compleath?  Yes 2  er (Specify)                        | cause of death bly 4 Unkr sy findings avai pletion of cause   |
| 4 hours after death.<br>Funerel Director: After this certificate has been signed by the attending<br>ely filled in by the funeral director, page 2 should be detached for use as | edical Certification; To Be Completed by | in the past 12 morths? 1   Yes 2   No 9   Unknown  Part II. Other significant conditions of the condit | Hospital:  28a. Date of Injur (Month, Day)  28e. Place of Injur  28e. Place of Injur  28e. Place of Injur                                      | it not resulting in the un  that not resulting in the un  that 2 ER/Outpatien  y  Year)  28b. Time of Injury  uny - At home, farm, stree.  (Specify)  of my knowledge, death examination and/or inv | t 3 DOA 28c. Injur Wor M 1 Document at the tire              | 26. Place of D  26. Place of D  ier: 4 \sum Nursing  y at k?  Yes 2 \sum No                              | 24a. Was a autops perform 1 Yes 2 eath Check onl on Home Reside 28d. Describe house, and due to the cap, and due to the cap.   | modes 2 12 No  n 24b. Vined? 2 12 No  n 24b. Vined? 2 12 No  n 1  e ance 6 □Other ow injury occurre treet and Number n, State)   | nibute to the  3 Probal  Were autops prior to compleath?  Leath?  er (Specify)  ed  er or Rural I    | cause of death bly 4  Unkn sy findings avail pletion of cause   |
| is certificate has been signed by the attending director, page 2 should be detached for use as   | Certification; To Be Completed by        | in the past 12 morths? 1   Yes 2   No 9   Unknown  Part II. Other significant conditions of the condit | Hospital:    1   Inpatiel   28a. Date of Injur (Month, Day building, etc.   28e. Place of Injur building, etc.   28e. Place of Injur building. | it not resulting in the un  that not resulting in the un  that 2 ER/Outpatien  y  Year)  28b. Time of Injury  uny - At home, farm, stree.  (Specify)  of my knowledge, death examination and/or inv | t 3 DOA 28c. Injur Wor M 1 Document at the tire              | 26. Place of D  er: 4 \sum Nursing  y at k?  Yes 2 \sum No  me, date and place pinion, death occurrence. | 24a. Was a autops perform 1 Yes 2 eath Check onl on Home X Reside 28d. Describe hot 28f. Location (St. City or Town ce, and due to the capurred at the time, described by the control of the capurred at the time, described by the capurred at the time, described by the capurred at the time, described by the capurred at the time, described by the capurred at the time, described by the capurred at the time, described by the capurred at the time, described by the capurred at the time, described by the capurred at the time, described by the capurred by the ca | modes 2 12 No  n 24b. Vined? 2 12 No  n 24b. Vined? 2 12 No  n 1  e ance 6 □Other ow injury occurre treet and Number n, State)   | nth Complete to the 3 Probal Were autops prior to complete th? Yes 2 Probal Probable of (Specify) ed | ocause of death or cause of death or cause of death or cause of death or cause or c |

|   | 1 - For State Registrar  | State of Ma  | aryland / Depa<br><i>Ce</i>              | artment of I<br>rtificate of                            |  |  | giene<br>1005               | 41935   |
|---|--|--|--|---|--|--|-----------------------------|---|
| hysician<br>/Medical  | I I TANA HAWS HAI  | ŕ  |  |   |  | 2. Date of Dea<br>Month<br>12/07/2         | Day Ye                      | 3. Time of Death<br>8:00 P                    |
| Examiner  | 4  | give street and number)                                    |  | 4b. City, Town,   | or Location of Death                                     |  | 4c. County of I             | Death   |
|   | Montgomery Hosp  | ice Casey Ho   | ouse                                     | Rockvi  |  |  | Montgo                      | mery  |
| ineral<br>rector  | 5. Social Security Number 006-14-9132                                    | 5. Sex 7. Ag<br>1 ☐ M 2 🛣 F                                | e (In yrs. last birthday)<br>84 Yrs.     | If Under 1 Year<br>Months Days                          |  | 8. Date of Birth<br>(Month, Day<br>07/25/1 | (, Year)                    | Birthplace (State or Fore<br>Country)<br>aine |
| de d  | Usual Residence of Decedent  10a. State  10b. County                     | 4,000  | 10c. City, Town or Lo                    |   |  |  |                             | 10d. Inside City Lim                          |
| octo  | Maryland Montg   | omery  | Silver Sp                                |   |  |  |                             |   |
| or D  | 10e. Street and Number   |  |  | 10f. Zip Code   |  |  | 10g. Citizen of Wha         | t Country?                                    |
| eral  | 3701 Internation   |  | Surviville 12                            | 20906   | Uli  |  | USA                         | American Indian                               |
| raumatic event, the Medical Examinat must be notified at To Be Completed by Funeral Director  | 11. Marital Status  1 Never Married 2 Marrie  3 Widowed 4 Divorced       | 12. Was Decedent Armed Forces?  1 Yes, Give Year or Dates: | No                                       | was Decedent of<br>If Yes, specify Cub<br>1 ☐ Yes 2X No | Hispanic Origin? (Sp<br>pan, Mexican, Puerto<br>Specify: | ecity Yes of No-<br>Rican, etc.)           | Specify:                    | American Indian,<br>White, etc.               |
| ed le   | 15. Decedent   |  | 16a Dece                                 | dent's Usual Occu                                       | nation   | 1  | 16b. Kind of Busin          | White   |
| Completed   | (Specify only highest<br>Elementary/Secondary (0-12)                     | grade completed)   | (Give                                    | kind of work done<br>DO NOT use retire                  | during most of work                                      | ting                                       | 100.11                      | 554dusiy                                      |
| E O   | Elementary/Secondary (0-12)  | College (1-4or 5   |  | e Admini  | strator  |  | Doctor's                    | Office  |
| BeC   | 17. Father's Name (First, Middle, L                                      | ast)   |  |   |  | e (First, Middle,                          | Maiden Sumame)              |   |
| 70 E  | Gerald McNally   | Hews   |  |   | Olive Lu   | rvey                                       |                             |   |
| Ang injuly of office (faulitation)  | 19a. Informant's Name/Relationsh   | p (Type, Print)  | 19b. Maili                               | ng Address (Stree                                       | and Number or Run  | al Route Numbe                             | r, City or Town, Sta        | te, Zip Code)                                 |
|   | Richard P. Fatu  | la/ Son  | 3923                                     | Winchest  | er Lane B  | owie, M                                    | D 20715                     |   |
| -   | 20a. Method of Disposition   |  | 20b. Place of Dispo                      | osition (Name of  | cel  | Date                                       | 20c. Location - Cit         | y or Town, State                              |
|   | 1 N Burial 2 □ Cremation<br>4 □ Donation 5 □ Other (Sp                   |  | Mary.<br>Veterans                        | natory or other pla<br>Land<br>Comotory                 | 12/1   | 2/2005                                     | Crownewill                  | 1 o MD  |
|   | 21. Signature of Funeral Service L                                       | censee   | 1 Veterails                              | 2. Name and Addr  | ess of Facility Rob                                      | ert E.                                     | Evans Fun                   | le, MD<br>eral Home                           |
| a   | 1 / Att  | -  | -  | 16000 Anr   | apolis Ro  | ad Bowi                                    | e. MD 207                   | 15  |
| Tor use as the buriar-transit of the contract |  | c  | a consequence of):                       |   |  |  |                             |   |
| Physician/Medic   | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 XNo | 23c. If yes, outcome 1 Live birth 4 Pregnant at            | 2 Fetal death 3                          | □Ectopic pregnanc<br>□ Other (specify) _                | у  |  | 23d. Date of Month          | delivery<br>Day Year                          |
| Phy   | 9 ☐ Unknown  |  |  |   |  |  |                             |   |
| þ   | 2  | s contributing to death b                                  | ut not resulting in the u                | nderlying cause gr                                      | ven in Part I.   |  |                             | te to the cause of death?  Probably 4 Unknow  |
| Completed   |  |  |  |   |  | 24a. Was a autops perform                  | med? deat                   |   |
| 5 0   | 25. Was case referred to medical   |  |  |   | 26. Place of Deat  |  |                             | 163 20160                                     |
| o o   | 1 ☐ Yes 2 🗓 No   | Hospital: 1 ☐ Inpatie                                      | int 2 ER/Outpatier                       | nt 3 DOA  |  |  |                             | Specify) Hospice                              |
|   |  | 28a. Date of Inju<br>(Month, Day                           | rv 28b. Time o                           | f 28c. Inju<br>Wo                                       |  |  | ow injury occurred          | Specify) HOS, ICE                             |
| Certification:  | 3 🗍 Suicide 6 🗎 Could no determine 4 🗍 Homicide determine                |  | ury - At home, farm, str<br>c. (Specify) | reet, factory, office                                   |  | 28f. Location (S.<br>City or Town          | treet and Number on, State) | r Rural Route Number,                         |
| edical  |  |  |  |   |  |  |                             |   |
| ž Ž   | 29b. Signature and title of certifier                                    | 01501  | S  | 29c. Licen:   | se number  | - 2  | 9d. Date signed (N          | lonth, Day, Year)                             |
|   |  | 20   | /  | D0505   | 345  |  | 12/08/200                   | 5   |
|   | 30. Name and address of person w   | ho completed cause of d                                    | eath (Item 23a) (Type,                   |   | -  |  | _,,,                        |   |
|   | Godswill O. Oko  |  |  |   | enue Tako  | ma Park                                    | , MD 2091                   | 2   |
|   | 31. Date filed (Month, Day, Year)  |  | ar's Signature                           |   |  |  |                             |   |

Fluhartpi Raymond arviand 21215-0036

|  |                  | For   | State of Marylan  |                        |  |                                |   | 9                             |   |
|--|------------------|---|---|------------------------|--|--------------------------------|---|-------------------------------|---|
|  |                  | 1 - State<br>Registrar  |   | Cei                    | rtificate of L   | Death                          |   | 2005                          | 41936   |
| Physici  | an               | 1. Decedent's Name (First, Middle, Last)  |   | 1 1                    |  |                                | 2. Date of Death<br>Month                   | Day Year                      | 3. Time of Death                                |
| /Medio   |                  | Raymond Arth  4a. Facility Name (If not institution, give s.  |   | luharty                |  | Location of Death              | December                                    | 4c. County of Dea             | 1-  |
| * LAMINI   | A.               | Baltimore Washington  |   | ker                    | Glen Bu  | irnie                          |   | Ane An                        |   |
| Funeral  |                  | 5. Social Security Number 6. Sex 13-22-5539   | 7. Age (In yrs. I   | ast birthday)<br>Yrs.  | If Under 1 Year<br>Months Days                                   | If Under 24 Hrs.<br>Hours Min. | 8. Date of Birth<br>(Month, Day, Ye         | 9. Bir                        | thplace (State or Foreign<br>ountry)            |
| Director   |                  | Usual Residence of Decedent   |   | 113.                   |  |                                | June 24,1                                   | 928   Ma                      | ryland  |
| ryland   |                  | 10a. State 10b. County  | 10c. City   | , Town or Lo           | cation   |                                |   |                               | 10d. Inside City Limits                         |
| Ba-f   | octo             | MD Anne Arun  | del Ga  | mbril.                 |  |                                |   |                               | 1 Yes 2 No                                      |
| with the sa or 2   | Funeral Director | 10e. Street and Number 545 2nd Street   |   |                        | 10f. Zip Code  | ,                              | 10g.  | Citizen of What Co            | ountry?   |
| death<br>me 23   | nera             |   | 2. Was Decedent Ever in U.  | S. 13. 1               | 2105<br>Was Decedent of Hi<br>f Yes, specify Cuba                |                                | ecify Yes or No-                            | USA<br>14. Race - Ame         |   |
| after<br>or its  |                  | 1 Never Married 2 X Marned  | Armed Forces? 1 X Yes 2 □ No ff Yes, Give 1055  |                        | f Yes, specify Cuba<br>1 □ Yes 2t\$ No                           | n, Mexican, Puerto<br>Specify: | Rican, etc.)                                | Black, Whit                   |   |
| hours a  | ed by            | 3 ☐ Widowed 4 ☐ Divorced  15. Decedent's Educ   | Year or Dates: 1933-  | 77                     |  |                                |   |                               | hite  |
| n na   | Completed        | (Specify only highest grade Elementary/Secondary (0-12)   | completed)  | (Give                  | ient's Usual Occupa<br>kind of work done o<br>DO NOT use retired | turing most of work            | ing   | . Kind of Business            | Industry  |
| ad with  | Com              | 12  | College (1-4or 5+)  | Carpe                  | enter  |                                | Na  | val Acade                     | emy   |
| d be file  | Be               | 17. Father's Name (First, Middle, Last)   |   |                        |  |                                | e (First, Middle, Mai                       | den Sumame)                   |   |
| r y lo   | 5                | Arthur Fluharty  19a. Informant's Name/Relationship (Typ  | a Print)  | 10b Mailie             | on Address (Chront o   | Mary E.                        |   |                               |   |
| is 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. I the stand and Mental Hygiene. I the stand so there then "natural", or itame 23s or 28s-1 show other traumatic event, the Medical Examinat must be notified at                             | l                | Doris Fluharty (Wi  |   |                        |  |                                | al Route Number, Ci $11\mathrm{s}$ , MD $2$ |                               | ZIP Code)                                       |
| item<br>item   |                  | 20a. Method of Disposition  |   | ace of Dispo           | sition (Name of natory or other place                            |                                |   | . Location - City or          | Town, State                                     |
| permit. Pages Department of P Important: If it eny injury or of  |                  | 1 X Burial 2 □ Cremation 3 □ Re<br>4 □ Donation 5 □ Other (Specify)   | moval from State  |                        | Vet. Cem   | 1                              | -2005 Cr                                    | ownsville                     | e, MD   |
| permit.<br>Depart<br>Import  |                  | 21. Signature of Punaral Service License  | 1   | 22                     | . Name and Addres  |                                | Home, P.                                    | Δ.                            |   |
| A  |                  | 23a, Part1. Enter me disease, or complic  | ations that caused the death  | . Do not ent           | 12 Ridge   | ely Avenu                      | Home, P.                                    | lis, MD 2                     | 21401<br>Approximate                            |
| Physician  |                  | 23a. Part1. Enter the disease, or complic<br>shock, or heart failure. List only one<br>Immediate Cause (Final |   |                        | the lung   |                                | or rospiratory arrest,                      |                               | Interval Between<br>Onset and Death             |
| /Medical   |                  | disease or condition resulting in death)  | Due to (or as a consequ   |                        | 2110 10/20   | , canw                         |   |                               |   |
| Examiner   | _                | Sequentially list conditions, b.  |   |                        |  |                                |   |                               |   |
| ted  | nine             | Sequentially list conditions, fany, leading to minimaliate cause. Enter Underlying Cause (Disease or injury   | Due to (or se a consequ   | ente of):              |  |                                |   |                               |   |
| be executed<br>be executed<br>ician and<br>burial-transit  | Examiner         | that initiated events c. resulting in death) Last   | Due to (or as a consequ   | ence of):              |  |                                |   |                               |   |
| w requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit  | icai             | d.  |   |                        |  |                                |   |                               |   |
| ertifica   | Physician/Med    | IF FEMALE:  |   |                        |  | 27/21                          |   |                               |   |
| attence for us   | cian             | in the past 12 months?  | <ul> <li>c. If yes, outcome of pregnar</li> <li>1 ☐ Live birth 2 ☐ Fetal</li> <li>4 ☐ Pregnant at time of de</li> </ul> | death 3                | Ectopic pregnancy Other (specify)                                |                                |   | 23d. Date of del<br>Month     | ivery<br>Day Year                               |
| oy the dached  | hysi             | 1 ☐ Yes 2 ☐ No<br>9 ☐ Unknown   | 9□ Unknown  |                        | Cition (specify)   |                                |   |                               |   |
| S, F<br>es tha<br>gned l   | by P             | Part II. Other significant conditions cont  |   |                        |  | on in Part I.                  | 23e. Did tobacc                             | o use contribute to           | the cause of death?                             |
| requir<br>een si   | ted              | chance obst   |   |                        | reore  |                                | 1 X Yes                                     | 2 □ No 3 □ Pr                 | obably 4 Unknown                                |
| e law<br>has b   | Completed        | coronary  | orterp dis  | esse                   |  |                                | 24a. Was an autopsy performed               | prior to                      | topsy findings available completion of cause of |
| VICAL PICC<br>sicion: The law<br>s certificate has b<br>lirector, page 2 sl  | ဝိ               | 25. Was case referred to medical  |   |                        | _  |                                | 1□ Yes 24                                   | ? death?<br>No 1 \(\sum Yes\) | 2 No  |
| ysicia<br>ysicia<br>is cert<br>direct  | To B             | examiner?   | spital:   | ER/Outpatien           | t 3 DOA Othe   | 26. Place of Death             | me 5 Residence                              | 6 ∏Other (Spe                 | cify)   |
| ng Ph<br>fter th   |                  | 27. Manner of Death  1 Natural 5 ☐ Pending  | 28a. Date of Injury<br>(Month, Day Year)  | 28b. Time of<br>Injury | 28c. Injury<br>Work  | at                             | 28d. Describe how in                        |                               | say,  |
| ttendi<br>death.<br>for: A   | icati            | 2 Accident investigation 3 Suicide 6 Could not be   | Do Die die  |                        |  | ′es 2 □No                      |   |                               |   |
| after<br>Direction by  | Certification:   | 4 Homicide determined   | 28e. Place of Injury - At hor building, etc. (Specify,  | ne, rarm, stre         | eet, factory, office   |                                | 28f. Location (Street<br>City or Town, St   | and Number or Hu<br>ate)      | iral Houte Number,                              |
| To the Hospital or Attending Physicien: The law requires that the death certificate I within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physis completely filled in by the funeral director, page 2 should be detached for use as the |                  | 29a. Certifier Certifying Physical Examina  | cian: To the best of my know  | vledge, death          | occurred at the tim  | e, date and place,             | and due to the cause                        | (s) and manner as             | stated.   |
| the Hin 24<br>the Fi   | fedicai          | one)  | and manner stated.  | ion and/or inv         | estigation, in my op   | inion, death occurr            | ed at the time, date                        | and place, and due            | to the cause(s)                                 |
| To<br>To<br>con  | ≥                | 29b. Signature and title of certifier   | Honno   |                        | 29c. License   | number<br>58719                | ,   | Date signed (Monti            |   |
|  | ì                | 30. Name and address of person where  | poleted cause of death (Item  | 23a) (Tuna 1           |  | 34 117                         | , ve  | cember 9                      | (2003   |
|  |                  | Albert Hav  | 1 17 301  | Hospin                 | -1 Drive   | Glen B                         | urne Me                                     | 21061                         |   |
| Sta  |                  | 31. Date filed (Month, Day, Year)  DEC 1 2 2005   | 1 PD 301  Registrar's Signate   | ure                    |  |                                |   |                               |   |
| Registr  | ar               | DEO T 9 (00)  | THE ST.   | 600                    | We I   |                                |   |                               |   |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Day Year Paul J. Fabian 2005 December 18 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner University Hospital-Shock Trauma **Baltimore** 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 11-13-1970 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Hours Days 1**√**M 2□F Months Min. 028-54-5241 35 Yrs Director Massachusetts Usuat Residence of Decedent with the Maryland 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits or 28a-f show the Medical Examiner must be nutified at Funeral Director 1 Yes 2 No Maryland | Anne Arundel Edgewater 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 238 218 Poplar Ave. 21037 USA filed within 72 hours after death or items 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian 1 □ Yes 2/2/No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No þ Specify: White 3 ☐ Widowed 4 ☐ Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12th Boat Technician Marine 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be life Depertment of Health and Mental Hy Important: If Item 27 is marked oth any linity or other traumatic event sone. 18. Mother's Name (First, Middle, Maiden Sumame) Be Edward C. Fabian Donna J. Lovelace 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Stacey L. Fabian/ Wife 218 Poplar Ave., Edgewater, MD 21037 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Kalas Crematory 12-23-05 Edgewater, MD of Funeral Service Licensee 21. Sign 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 111 /Medical Due to (or as a Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transit and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, ted by the attending physicien detached for use as the buria Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 2 | Fetal death 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? cate hes been signification of the category of 1 Yes 2 No 3 Probably 4 Nunknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Ves 2 □ No 24a. Was an autopsy performed? 1 Yes 2 □ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Yes 2 □ No Hospital: Other: ဥ 2 ☐ ER/Outpatient 3 ☐ DOA 1 X Inpatient 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation 1 Natural Injury yet outerey list in brotory ch 1 ☐ Yes 2 No death. 2 Accident 211865 1624 Howas Director: 6-cail 3 🗌 Suicide 6 □ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Trum Buil Route Number, 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) á 4 | Homicide Edgust within 24 hours a

To the Funeral C

completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manual as sales.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. December 19, 2005 30. Name and address of person who completed cause death (Item 23a) (Type, Print) ItE with Mykin 111 Penn Street, Baltimore, Maryland 21201 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

DEC 2

7 2005

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar ReguloU U 5 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Month Mary Myrtle Fraley 4a. Facility Name (If not institution, give street and number) 4b City Town or Location of Death 4c. County of Death Year If Under 24 Hrs. acred II Under 1 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) 9. Birthplace State or Foreign Country) Months Days Hours Min 1□M 2∑F Yrs. 218-16-4204 80 16-Oct-1925 Maryland Usual Residence of Decedent 10a State 10c. City, Town or Location 10b County 10d. Inside City Limits 1 Yes 2 □ No Maryland Allegany Frostburg 10e. Street and Number 255 Centennial Street Extended 10f. Zip Code 10g. Citizen of What Country? 21532-U.S.A 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 Drivo If Yes, Give/ Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1□Yes 2No Specify: 3 Widowed 4 □ Divorced Specify White 16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) during most of working Elementary/Secondary (0-12) College (1-4or 5+) homemaker homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, George Bennett Lillian Lancaster 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10033 Winners Lane, Carol Winebrenner daughter Frostburg Maryland 21532 20b. PlaceNorWisposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Frostburg Memorial Park 10-Dec-2005 Frostburg 21. Signature of Funeral Service Light 22. Name and Address of Facility Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532 unc olly 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, mock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Acute Myo cardia disease or condition resulting in death) Days consequence of): DROWARY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Probably 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 ☐ Yes 2/ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: patient Other: 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No

The law requires that the death certificate be executed attending physicien and for use as the burial-transit P.O. Box 68760, sate has been signed by the a page 2 should be detached Division of Vital Records, certificate or Attanding Physician: : After this certifical funeral director,

Examiner Physician/Medical Completed by Be

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**Physician** 

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Pages 1 and 2 should be filed within 72 hours after death with

Baltimore, Maryland 21215-0036

To the Hospital or At within 24 hours after of To the Funerel Direct completely

> State Registrar

28e. Place of Injury - At home, larm, street, lactory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number

29d. Date signed (Month, Day, Year)

D 26907

DEREMBER 7, 2005

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6 Could not be

3 Suicide

31. Date filed (Month, Day, Year)
DEC 0 8 2005

Bishop Walsh Road, Cumberland, MD 21502 925 32. Registrar's Signature Goode

|  |  |   | 1 - For<br>State<br>Registrar  | State  | of Maryla  | nd / Depa  | artment of<br><i>rtificate o</i>   |  |                              |  | giene  | INE  | 1.1020   |
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| 0  | O <sub>N</sub>   | 46  | Decedent's Name (First, Michael Control of the      | Idle, Last)  | ·  |  | rimouto o  | , Dodi,  |                              | 2. Date of Dea   | ith  | I U J  | 3. Time of Death   |
|  | Physici<br>/Medic  |   | Holdred L  | - Gark   | per  |  |  |  |                              | Month<br>12  | Day  | Year<br>O.5  | 0140 AM  |
|  | Examir   |   | 4a. Facility Name (If not institut   | ion, give street and i   | number)  |  | 4b. City, Town   | , or Location of   | of Death                     |  |  | ounty of Death   |  |
|  |  |   | Coastal Hospic   |  | Lake   |  | Salisbe  |  | 1D                           |  |  | comi   |  |
|  | Funeral<br>Director  |   | 5. Social Security Number 215–26–5467  | 6. Sex<br>1 ☐ M 2 1 F  | 7. Age (in yrs   | s. last birthday)<br>Yrs.  | Months Day   | s Hours  |                              | Month, Day   |  | Cour   | • •  |
| (C)                                      | D  |   | Usual Residence of Decedent  |  |  |  |  |  |                              | 05/23/1  | 1930   | Mary   | Land   |
|  | anytan<br>show   | _   | 10a. State 10b. Cour   | ity  | 10c. C   | City, Town or Lo   | ocation  |  |                              |  |  | 1  | Od. Inside City Limits   |
|  | be Mis   | Director  |  | rset   | P  | rincess  |  |  |                              |  |  |  | 1 Yes 2 □ No   |
|  | with t   | ă   | 10e. Street and Number   | 1  |  |  | 10f. Zip Code  |  |                              |  |  | n of What Cour   | ntry?  |
|  | death<br>ms 23   | by Funerai  | 11974 Edgehil  | 12. Was De   | ecedent Ever in I  | U.S. 13.   | Was Decedent o   | 1853<br>of Hispanic Ori  | igin? (Spec                  | fy Yes or No-  |  | Race - Americ  | can Indian,  |
| ထွ                                       | or ite   | F   | 1 Never Married 2 M  | arried 1 TYes  | Forces?<br>s 2 No  |  | If Yes, specify Ci   |  |                              | ican, etc.)  |  | Black, White,  |  |
| 21215-0036                               | within 72 hours after death with the Maryland<br>ene.<br>than "natural", or items 23a or 28a-f show<br>the Madical Exeminar must be notified at  | d b   | 3 Widowed 4 □ Divorc   | ed Year or   | Dates:   |  |  |  |                              |  |  |  | ite  |
| 15                                       | n 72 in 72 in at   | Completed   | (Specify only high   | ent's Education<br>hest grade complete   |  | (Give  | dent's Usual Occ<br>kind of work dor<br>DO NOT use reti  | ne during mos  | t of working                 | 9  | 16b. Kind  | of Business/Ind  | dustry   |
| 212                                      | filed withi<br>Hygiene.<br>other ther  | E O   | Elementary/Secondary (0-12   | ) College<br>none  | (1-4or 5+)   |  | ent Man  |  |                              |  | Towni  | nouses   | Rental   |
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| <u>yla</u> ı                             | should be<br>nd Mental<br>marked o   | To To   | John Paul Brid   |  |  |  |  |  |                              | oodswor  |  |  |  |
| Maryland                                 | 12 sh<br>h and<br>7 is m<br>rraum  | w 1   | 19a. Informant's Name/Relation Deborah Thomas  |  |  |  | ng Address <i>(Stre</i><br>Hayman  |  |                              |  |  |  |  |
|  | 1 and 2<br>Health<br>Ism 27<br>other tru   |   | 20a. Method of Disposition   | o/Daugnter   |  |  | nay man<br>esition (Name of<br>matory or other p   |  | , FIII                       |  |  | tion - City or To  |  |
| JOH.                                     | Pages<br>nent of<br>int: If it<br>iry or o   |   | N⊠Burial 2 ☐ Crematio<br>4 ☐ Donation 5 ☐ Other  |  | III State  |  | natory or other p  Cemete:   | 1  | 12/08                        | /2005 1  |  | ess Ann  |  |
| altimore,                                | permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hydene. Department of Health and Mental Hydene. Department: If itsm 27 is marked other than "natural; or items 23a or 28a-f show sny injury or other traumatic avant, the Maclical Examinat must be notified at ODEs. | /   | Signature of Funeral   |  | )  |  | Name and Add   | -  |                              | /2005 1  | LINCE  | saa Aliii  | e, no  |
| m  | 9 0 m 9  | V   | MODKY  | (KNA)  | 4 MOO2   | 95 11  | 673 Som  | erset  | Ave                          | Prince   | 255 A  | nne. MD  | 21853  |
| 49                                       |  |   | 3a. Part1. Enter the disease, shock, or heart failure. L   | or complications that<br>ist only one cause or   | it caused the dea  | ath. Do not ent  | er the mode of d   | tying, such as   | cardiac or                   | respiratory arr  | est,   | , ,  | Approximate  |
| 5-<br>26-                                | Physician  | 1   | Immediate Cause (Final   | <u></u>  |  |  | 0  |  |                              |  |  |  | Interval Between   |
|  | 10.0171  |   | disease or condition   | _a O   | mall   | Bou  | el c   | Obstr  | ruti                         |  |  | 7  | Onset and Death  |
| 197.<br>198                              | /Medical<br>Examiner   |   | resulting in death)  | a Oue t  | to (or as a conse  | Boue   | el (   | Obstr  | ruti                         |  |  | 0  |  |
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| vision of Vital Records, P.O. Box 68760, | Attending Physician: The law requires that the death certificate be executed to death.  To death.  Settler: After this certificate has been signed by the attending physician and most the funeral director, page 2 should be detached for use as the burial-transit   | edicai Certification: To Be Compieted by Physician/Medical  | resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 pronths? 1   Yes   No 9   Unknown Part II. Other significant cond  25. Was case referred to mediexaminer? 1   Yes   No 27. Manner of Death   Natural   5   Pen   2   Accident   Inve   3   Suicide   6   Cou   dete   29a. Certifier (Check only one)  | b  | to (or as a consection (or | pquence of):  nancy tal death 3 [ death 5 [ death 5 [ death 5 [ death 5 [ death 5 [ death 5 [ death 5 [ death 5 [ death 5 [ death 5 [ death 5 [ death 5 [ death 5 [ death 5 [ death 5 [ death 5 [ death 6 [ de | Dectopic pregnar Other (specify)  Inderlying cause  Int. 3 DOA  In | 26. Place Other: 4 Nu lyork? Yes 2 itme, date an y opinion, deal | o of Death (sursing Home) 28 | 23e. Did to 1 Yes 24a. Was a autopup perfor 1 Yes Check only or 5 Residud. Describe his Location (S. City or Town d due to the collat the time, d  | bacco use es 22N med? No med and N n, State) ause(s) anuate and pla ause(s) anuate and pla | Month  contribute to the contribute to the contribute to the contribute to the contribute to the contribute to the contribute to the contribute to contribute to the contribut | onset and Death)  NO MONTH  Day Year  Day Year  Day 4 Unknown  Day findings available mpletion of cause of caus |
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| vision of Vital Records, P.O. Box 68760, | trending Physician: The law requires that the death certificate be executed death.  The death.  After this certificate has been signed by the attending physician and mortor. After the funeral director, page 2 should be detached for use as the burial-transit unit.  | Medical Certification: To Be Completed by Physician/Medical | resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 gronths? 1   | b  | to (or as a consection (or | programment of the programment o | Dectopic pregnar Other (specify)  Inderlying cause  Int. 3 DOA  In | 26. Place Other: 4 Nu lyork? Yes 2 itme, date an y opinion, deal | o of Death (sursing Home) 28 | 23e. Did to 1 Yes 24a. Was a autopup perfor 1 Yes Check only or 5 Residud. Describe his Location (S. City or Town d due to the collat the time, d  | bacco use es 22N med? No med and N n, State) ause(s) anuate and pla ause(s) anuate and pla | Month  contribute to the contribute to the contribute to the contribute to the contribute to the contribute to the contribute to the contribute to contribute to the contribut | onset and Death)  NO MONTH  Day Year  Day Year  Day 4 Unknown  Day findings available mpletion of cause of caus |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Fattle Registrar #31, Per Health Dept., 12/13 Certificate of Death 05, W.C.H.Deeg. No. 0. 1.5 Amended Item Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav Month **Physician** Year 1438 P.M 12 2005 08 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Peninsula Regional Medical Center Salisbury
If Under 1 Year If Under 24 Hrs. WILDMICO 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 M 2□F Min. -48-817 50 Yrs Director La. Usual Residence of Decedent 10a State 10b. Count 10c. City, Town or Location 10d. Inside City Limits 28e-f ehov other traumatic event, the Medical Examiner round be notified at 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 52 Iteme 23a d Funerai Was Decedent Ever in U.S. Armed Forces? 1 MYes 2 □ No 19 (a) 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 5 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 þ Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced 1974 "naturel" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 end 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 ie marked other than "na eny injury or other traumatic event, the Mental 2008. Elementary/Secondary (0-12) College (1-4or 5+) 9 rade Jes 1erk 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Walker Ben 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20d. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Minktorn Date 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Dother (Specify) 12-17-05 Pocomoke en. 21. Signature of Funeral Service Licen 22. Name and Address of Facility Bennie Smith Funeral POLOMOKE , 0: BOX 331 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Insufficience **Physician** espiratory 6 hs /Medical Due to (or as a consequence of): Examiner Tultiongan

Due to (or as a consequence of): da Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): that initiated events resulting in death) Last 68760. Physician/Medical Cirrhosis Box ( IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day 4☐Pregnant at time of death 5 ☐ Other (specify) Division of Vital Records, P.O. been signed by the should be detached 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Abuse 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No Hepatitis 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? certificate Hypertension
25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No director, Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 2 No 1 Tyes 2 ER/Outpatient 3 DOA After thi 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? Certification: 28d. Describe how injury occurred 1 Naturat
2 Accident 5 Pending investigation within 24 hours after death.
To the Funerel Director: Af death. 1 ∏Yes 2 ∏No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital Certifying Physician: To the best of my knowledge death occurred at the time, date and place, and due to the eause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certified 29c. License numbe 29d. Date signed (Month, Day, Year) MD D63499 (Maryland) 12/12/05 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 12137 Ullson Mino ElmSt

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

**DEC 13** 

2005

32. Régistrar's Signature

|             |   |                  | For State   | State of Ma                            | aryland      |                             | artment of<br>tificate of             |                |               |                                   | 000             | p-m              | 1 101 1                                      |     |
|-------------|---|------------------|---|--|--------------|-----------------------------|---------------------------------------|----------------|---------------|-----------------------------------|-----------------|------------------|--|-----|
|             |   |                  | Registrar  1. Decedent's Name (First, Middle, Last)   |  |              | Cei                         | uncate of                             | Dealii         |               |                                   | g. No.          | J                | 4 1 9 4                                      |     |
| ı           | Physici<br>/Medio   |                  | Joseph Sherman  |  | Sr.          |                             |                                       |                |               | Date of Death Month ecembe        |                 | o d d s          | 3. Time of Death 10:30p                      |     |
|             | Examir  | ier              | 4a. Facility Name (If not institution, give s   |  |              |                             | 4b. City, Town,                       |                | of Death      |                                   | 4c. County      | of Death         |  |     |
|             |   |                  | Southern Maryla   |  |              |                             | Clint                                 |                |               |                                   | Prin            | ce G             | eorge  |     |
| ì.          | Funeral   |                  | 5. Social Security Number 6. Sex  | 111 000                                |              | ast birthday)<br>Yrs.       | If Under 1 Yea Months Days            |                | Min.          | Date of Birth (Month, Day, uly 7, | Year)           | Coun             |  | gn  |
| Н           | Director  |                  | 212-62-1458 <sup>1K</sup> Usual Residence of Decedent   | 5                                      | 3            | 113.                        |                                       |                | J.            | uly 7,                            | 1952            | Mar              | yland  |     |
|             | /land   |                  | 10a. State 10b. County  |  | 10c. City,   | Town or Lo                  | cation                                |                |               |                                   |                 | 1                | Od. Inside City Limit                        | ts  |
|             | Mary<br>f sh  | ģ                | Maryland Charle   | s                                      | La           | Plata                       | L                                     |                |               |                                   |                 |                  | 1 □ Yes 2√□ N                                |     |
|             | r 28e   | rec              | 10e. Street and Number  |  |              |                             | 10f. Zip Code                         |                |               | 10                                | g. Citizen of V | Vhat Coun        | try?   |     |
|             | h with  | <u>e</u>         | 12700 LaPlata Ro  | ad                                     |              |                             | 20                                    | 646            |               |                                   | U.S.A           |                  | •  |     |
|             | deat deat   | Funeral Director | 11. Marital Status  | 2. Was Decedent I                      | Ever in U.S  | i. 13. V                    | Vas Decedent of<br>Yes, specify Cul   |                | gin? (Specif  | y Yes or No-                      | 14. Race        | e - Americ       |  | _   |
| စ္          | or its  | 교                | 1 Never Married 2 Married   | 1 XYes 2 1                             | 10           |                             | Tes, specify Cui                      |                | i, Puerto Ric | can, etc.)                        |                 | k, White,        |  |     |
| 9           | ours,   | d by             | 3 ☐ Widowed 4 ☐ Divorced  | Year or Dates:                         |              |                             | 103 250140                            | эрвспу.        |               |                                   | Specity         | Bla              | CK   |     |
| 215-0036    | be filed within 72 hours after death with the Maryland lat Hygiene. d other than "netural", or items 23s or 28e-f show event, I're Medical Exercitral reset be notilised at   | Completed        | 15. Decedent's Educ<br>(Specify only highest grade  | ation<br>completed)                    |              | (Give                       | ent's Usual Occu<br>kind of work done | durina most    | t of working  | 1                                 | 6b. Kind of Bu  | siness/Inc       | ustry  |     |
|             | withir<br>ane.<br>then  | du               | Elementary/Secondary (0-12)   | College (1-4or 5                       | +)           |                             | OO NOT use retin                      |                |               |                                   | TT '            |                  |  |     |
| 22          | Hygie<br>thar<br>int, II  | ပိ               | 17. Father's Name (First, Middle, Last)   |  |              | F. T.C                      | or Tec                                |                |               | First, Middle, M                  | Hospi           |                  |  |     |
| Maryland    | 0 m 5 ×   | Be c             | Paul Gray   |  |              |                             |                                       |                |               |                                   |                 |                  |  |     |
| 2           | should<br>nd Men<br>marks<br>umatic   | 2                | 19a. Informant's Name/Relationship (Typ   | na Print)                              |              | 10h Mailin                  | g Address (Stree                      |                | gare          |                                   |                 | kins             |  |     |
| <u>8</u>    | d 2 s<br>th an<br>t7 ie<br>trau   |                  | Joseph Sherman G  |  | Sor          |                             |                                       |                |               |                                   |                 |                  | <sup>Содө)</sup><br>Id <b>.</b> 20723        |     |
| வ்          | es 1 and 2 should to the alth and Ment litem 27 ie marked rother traumatice   |                  | 20a. Method of Disposition  | ray, or                                |              |                             |                                       |                |               |                                   | Oc. Location -  |                  |  | -   |
| Baltimore,  | permit. Pages Department of I Importent: If It eny Injury or o  |                  | 1 ☑ Burial 2 ☐ Cremation 3 ☐ Re<br>4 ☐ Donation 5 ☐ Other (Specify)   | emoval from State                      | cer          | metery, cren                | atory or other pla                    | Dec            | .14,2         | 2005 _                            |                 | •                |  |     |
|             | orten   |                  | 21. Signature of Funeral Service License  | <b>e</b>                               | ) SL         | · CIIG                      | rles Co                               | SINC GC        | т у           |                                   | ndian           | Неа              | d, Maryl                                     | .aı |
| ñ           | Ded on o  |                  | malast  |  | M006         | 668                         | Willian                               | ns Fu          | nera]         | L Home                            | , P.A.          | •                | 20640<br>d, Md.                              |     |
|             |   |                  | 23a. Part1. Enter the disease, or complic   | ations that caused                     | the death.   | Do not ente                 | 4270 Ha                               | ng, such as o  | rne i         | espiratory arres                  | ndian<br>st     |                  | Approximate                                  | _   |
|             | Physician   |                  | Immediate Cause (Final  | e cause on each lin                    | e.           | 1 . 7                       | 1.1.                                  |                |               |                                   |                 |                  | Interval Between<br>Onset and Death          |     |
|             | /Medical  |                  | disease or condition resulting in death)  | Due to (or as a                        | CONSEGUE     | mce of):                    | MICIL                                 | Ng             |               | 100                               |                 | 6                | mlinous                                      | _   |
|             | Examiner  |                  |   |  |              | 31.00 01).                  |                                       |                |               |                                   |                 |                  |  |     |
|             |   | Jer              | Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying Cause (Disease or injury | Due to (or as a                        | conseque     | ince of).                   |                                       |                |               |                                   |                 |                  |  |     |
|             | cuted<br>nd<br>ransi  | Examiner         | that initiated events C.  |  |              |                             |                                       |                |               |                                   |                 |                  |  |     |
| Š           | e exe<br>ien a<br>urial-i   |                  | resulting in death) Last  | Due to (or as a                        | conseque     | ence of):                   |                                       |                |               |                                   |                 |                  |  |     |
| 2/60        | ficate be executed<br>physicien and<br>s the burial-transit   | dicai            | d.  |  |              |                             |                                       |                |               |                                   |                 |                  |  |     |
| ٥           | certific<br>nding p   |                  | IF FEMALE:  |  |              |                             |                                       |                |               |                                   |                 | Ukaros           | _  |     |
| X<br>O<br>D | death ce<br>e attend<br>ed for us   | an/              | 23b. Was decedent pregnant in the past 12 months?   | lc. If yes, outcome of<br>1□Live birth | 2 🗌 Fetal d  | leath 3 🗌                   | Ectopic pregnanc                      | у              |               |                                   |                 | of deliver       | •  |     |
| -           | the a   | Physician/Me     | 1 Yes 2 No  | 4☐ Pregnant at 1<br>9☐ Unknown         | time of dea  | ıth 5□                      | Other (specify) _                     |                |               |                                   | Mon             | tn t             | Day Year                                     |     |
| ŗ.          | hat If  | P.               | Part II. Other significant conditions cont  | ributing to death bu                   | t not recult | ing in the un               | darhian anuan a                       | in Daniel      |               | One Distant                       |                 |                  | 7.   |     |
| gs,         | w requires that the death certif<br>been signed by the attending<br>should be detached for use a  | d by             | HUDOKalimi  | lad                                    | 11101193410  | ang in the dr               | derlying cause gr                     | ven in Fait i. |               |                                   | _               | oute to the<br>3 | cause of death?                              |     |
|             | requ<br>been<br>shout   | Completed        |   | 1 2:                                   |              |                             |                                       |                | !!            | 1 185                             |                 | 3 [] FIODA       | bly 4 Linknown                               | 1   |
| ຍ           | has<br>has  | ם                | Throussough   | ofene                                  | 6-           |                             |                                       |                |               | 24a. Was an autopsy               | pr              | for to com       | sy findings available<br>pletion of cause of | Э   |
| <u>-</u>    | n: Th   |                  |   |  |              |                             |                                       |                |               | performe<br>1 ☐ Yes 2             |                 | eath?<br>□Yes 2  | .□ No  |     |
| 2           | iciar<br>certif<br>recto  | Be               | 25. Was case referred to medical examiner?  | spital:                                |              |                             | . 04                                  |                |               | heck only one                     |                 |                  |  |     |
| 5           | Phys  | 2                | 1 Yes 2 D46   | 28a. Date of Injun                     |              | R/Outpatient<br>8b. Time of | 3 DOA                                 |                |               | 5 Residen                         |                 |                  |  |     |
| 5           | ding<br>P.<br>After<br>fune   | ij               | 1 Natural 5 Pending   | (Month, Day                            | Year)        | Injury                      | 28c. Inju<br>Wo                       |                |               | . Describe how                    | injury occurre  | d                |  |     |
| 101517      | deat<br>deat<br>ctor:<br>y the  | lica             | 3 ☐ Suicide 6 ☐ Could not be  | 28e. Place of Inju                     | nı - At hom  | a form stra                 |                                       | Yes 2 □ N      |               | Lanation (Ctm                     |                 |                  |  |     |
| 2           | after<br>Dirs   | Certification    | 4 Homicide determined   | building, etc.                         | (Specify)    | o, laini, sile              | et, ractory, onice                    |                | 201.          | Location (Stre<br>City or Town,   | State)          | r or Hurai       | Houle Number,                                |     |
|             | epite   |                  | 29a. Certifier 1 Certifying Physi   | cian: To the best o                    | f my knowle  | edge death                  | occurred at the ti                    | me date and    | I place, and  | due to the cau                    | co/s) and man   |                  |  |     |
|             | P Fu  | Medical          | (Check only 2 Medical Examine   | er: On the basis of and manner stat    | examinatio   | n and/or inv                | stigation, in my                      | pinion, death  | h occurred a  | at the time, date                 | e and place, ar | nd due to t      | he cause(s)                                  |     |
|             | To the Hospital or Attending Physician: The law requires that the within 24 hours after death.  To the Funerel Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detached. | ž                | 29b. Signature and title of certifier   | A                                      |              |                             | 29c. Licens                           | e number       |               | 290                               | I. Date signed  | (Month, D        | ay, Year)                                    |     |
|             |   |                  | Bort 3.11   | Vinn                                   |              |                             | 500                                   | 154            | ,             | 0                                 | 010 ms          | Ben              | 10,05  |     |
| 1           | 2 1   |                  | 30. Na e and address of p o who com   |  |              |                             | rint)                                 | ,              |               |                                   |                 | - /)             | 10)00  | -1  |
| D           | 1710  |                  | 986/ 6-eapfin A   | ve 3 -                                 | e1 8         | lves                        | 1651, N                               | 3 M            | 0             | 2090                              | 2_              |                  |  |     |
|             | Stat<br>Registra  |                  | 31. Date filed (Month, Pay, Year)   | 32. R. distra                          | r's Signatur | B. D                        | rante                                 |                |               |                                   | 11.11.77        |                  |  |     |
|             |   |                  |   |  |              |                             |                                       |                |               |                                   |                 |                  |  |     |

DHMH 17 Rev 1/2001

eraldW.Gastor

|                     |  |                 | 1 = For Stete Registrar   | State of Mary                                      |  | artment o  |                |                             |   | giene                           | 41943   |
|---------------------|--|-----------------|---|--|--|--|----------------|-----------------------------|---|---------------------------------|---|
|                     | Di   |                 | 1. Decedent's Name (First, Middle, Las  | )  |  |  |                |                             | 2. Date of Dea  | ath                             | 3. Time of Death                                    |
|                     | Physic<br>/Medi  |                 | Geraldine   | Eliz   | zabeth                                 | Gordon   |                |                             | Month DECEMBE   | Day Yes<br>R 14.2005            | 13:58 P M   |
|                     | Exami  |                 | 4a. Facility Name (If not institution, give   | street and number)                                 |  | 4b. City, Tov  | wn, or Loc     | ation of Death              | DHOLLIDE  | 4c. County of D                 |   |
|                     |  |                 | MEMORIAL HOSPITAL   |  |  | CUMBER   | LAND           |                             |   | ALLEGAN                         | Y   |
|                     | Funeral  |                 | 5. Social Security Number 6. Se   | M OFFE   | yrs. last birthday)                    | If Under 1 Y<br>Months Da  |                | Under 24 Hrs.<br>lours Min. | 8. Date of Birt<br>(Month, Day  |                                 | Birthplace (State or Foreign Country)               |
|                     | Director   |                 | 217 17 3022   | 81   | Yrs.                                   |  |                |                             | 02/10/19  | 01                              | aryland   |
|                     | land   |                 | Usual Residence of Decedent  10a. State 10b. County   | 100  | c. City, Town or Lo                    | ocation  |                |                             |   |                                 | 10d. Inside City Limits                             |
|                     | Mary<br>f sh   | ğ               | MD Allegat  |  | ,                                      | 21 1   | 1              |                             |   |                                 | 1 √ Yes 2 No  |
|                     | the  | Director        | MD Allegat  | ıy   |  | 10f. Zip Co  |                |                             |   | 10g. Citizen of What            |   |
|                     | h with   | D               | 221 Cecelia S   | treet  |  |  | 2150           | 2                           |   | USA                             | Country   |
|                     | hours after death with the Maryland<br>tural', or Itams 23a or 28e-f show<br>al Everalizer mast be notified at | Funeral         | 11. Marital Status  | 12. Was Decedent Ever                              | in U.S. 13.                            | Was Decedent   | of Hispar      | nic Origin? (Sp             | ecify Yes or No-<br>Rican, etc.)  | 14. Race - A                    | merican Indian,                                     |
| 9                   | after<br>or Ita  | 正               | 1 Never Married 2 Married   | Armed Forces?<br>1 ☐ Yes 2 ☒ No<br>If Yes, Give    |  | _  |                |                             | Rican, etc.)  |                                 | hite, etc.  |
| 8                   | ural',   | d by            | 3 X Widowed 4 □ Divorced  | Year or Dates:                                     |  | 1□Yes 2∏   | No Sp          | pecify:                     |   | Specify:                        | Black   |
| 7                   | 72   | Completed       | 15. Decedent's Edu<br>(Specify only highest grad  | cation<br>e completed)                             | (Give                                  | dent's Usual Oo<br>kind of work do   | one durine     | g most of work              | ing   | 16b. Kind of Busine             | ss/Industry   |
| 12                  | within<br>ene.<br>than   | E               | Elementary/Secondary (0-12)   | College (1-4or 5+)                                 | life. I                                | DO NOT use re  | etired)        |                             |   |                                 |   |
| 92                  | be filed<br>ital Hygie<br>od other   | e Co            | 12<br>17. Father's Name (First, Middle, Last)   |  |  | Homemakeı  |                | Mothor's Name               | /First Middle   | Home Maiden Sumame)             |   |
| an                  | Q 5 0 0  | To Be           | Alonza  | James  | Peck                                   |  | 10.            | Pearl                       |   | ,                               | W 1   |
| Maryland 21215-0036 | 2 should to and Ment is marked   | -               | 19a. Informant's Name/Relationship (T)  |  |  | na Address (Str  | reet and N     |                             |   | rille<br>r, City or Town, State | Males   |
|                     | 2 # Z # Z  |                 | Woodrow H. Gordon, J:   | r. / son   |  |  |                |                             |   | land 21502                      | , 210 0000)   |
| altimore,           | of Head  |                 | 20a. Method of Disposition  |  | b. Place of Dispo<br>cemetery, cren    | sition (Name o   | of             |                             | CONTRACTOR OF THE PARTY OF THE | 20c. Location - City            | or Town, State                                      |
| <u>Ĕ</u> .          | permit. Pages. Department of I<br>Important: If its<br>any injury or of  |                 | 1 🕅 Burial 2 □ Cremation 3 □ F  4 □ Donation 5 □ Other (Specify)  |  | Sunset Mem                             |  |                | 12/17/2                     | 2005  | Cumberland,                     | Maryland  |
| at                  | permit. Pa<br>Departmer<br>Important:<br>any injury<br>once.   |                 | 21. Signature of Funeral Service Licens   | 98,  | 22                                     | . Name and Ad  | ddress of      |                             |   | ly Funeral H                    |   |
| 8                   | 205 20   |                 | Takent Call   | clams  |  |  |                | Street, (                   | Cumberland  | d, Maryland                     |   |
|                     |  |                 | 23a. Part1. Enter the disease, or compl<br>shock, or heart failure. List only or                            | cations that caused the cause on each line.        | leath. Do not ente                     | er the mode of   | dying, su      | ch as cardiac c             | r respiratory arr   | est,                            | Approximate<br>Interval Between                     |
|                     | Physician  |                 | Immediate Cause (Final disease or condition   | Hupoxis  | For                                    | unha   | 20/20          | cho                         | 1   |                                 | Onset and Death                                     |
|                     | /Medical<br>Examiner   |                 | resulting in death)   | Due to (or as a con                                | sequence of);                          | Jh. 1  |                |                             | ),  |                                 | 193   |
| ŀ.                  |  | -               | Sequentially list conditions,   | Due to (or as a con                                | DUIC                                   | nonor  | M              | arre                        | St  |                                 | days  |
|                     | rted   | nin             | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | C  | sequence or).                          | 2450   | _ )            |                             |   |                                 |   |
| Ć.                  | execu<br>n and<br>ial-tra  | Examiner        | that initiated events resulting in death) Last  | Due to (or as a con                                | sequence of):                          | 701 GO   | , (            |                             |   |                                 | years   |
| 8760,               | cate be executed<br>physician and<br>the burial-transit  | dicai           |   | l  |  |  |                |                             |   |                                 |   |
| 9                   | ntifica<br>ng ph<br>as th  | Jedi            | IF FEMALE   |  |  |  |                |                             |   |                                 |   |
| Box                 | leath certific<br>attending p<br>I for use as I  | an/h            | Fragitalis  | 3c. if yes, outcome of pre<br>1 ☐ Live birth 2 ☐ F |  | Ectopic pregna   | ancv           |                             |   | 23d. Date of d                  | elivery   |
| o.                  | that the death cer<br>ed by the attendir<br>detached for use   | by Physician/Me | in the past 12 months?  | 4☐ Pregnant at time of                             |  | Other (specify   |                |                             |   | Month                           | Day Year  |
| <u>Ф</u>            | hat th<br>d by<br>fetach   | Ph              | 9 ☐ Unknown  Part II. Other significant conditions cor  |  |  |  |                |                             |   |                                 |   |
| Records,            | es<br>gu<br>be   |                 | Tarrii. Othor significant conditions con  | mouning to death but not                           | resulting in the un                    | ideriying cause  | givenini       | Рап I.                      | 23e. Dig tot  |                                 | to the cause of death?                              |
| Ö                   | w requir<br>been si<br>should  | ete             |   |  |  |  |                |                             |   |                                 | Probably 4 Unknown                                  |
| Re                  | The lavate has   | Completed       |   |  |  |  |                |                             | 24a. Was ai<br>autops<br>perforn  | n 24b. Were a<br>y prior to     | utopsy findings available<br>completion of cause of |
| Vita                |  | e C             | 25. Was case referred to medical  |  |  |  |                |                             | 1 ☐ Yes 2   | 2 □ No 1 □ Ye                   |   |
|                     | Physician:<br>r this certificatal director,  | 0               | examiner?   | ospital: 1 Inpatient 2                             | P □ ER/Outpatient                      | 3 DOA  | Oah            |                             | (Check only on  | 177                             |   |
| ot                  | g Phy<br>er thi  | D: 1            | 27. Manner of Death   | 28a. Date of Injury<br>(Month, Day Year            |  | 28c. Ir  | njury at       |                             |   | nce 6 Other (Sp                 | ecify)  |
| 0                   | Attanding Pr<br>ir death.<br>ector: After th<br>by the funeral   | atio            | 1 Pending 2 Accident investigation  | (Month, Day Fear                                   | ) Injury                               |  | Vork?<br>☐ Yes | 2 🗆 No                      |   |                                 |   |
| Division            | P S S  | Certification:  | 3 ☐ Suicide 6 ☐ Could not be determined   | 28e. Place of Injury - A<br>building, etc. (Spe    | t home, farm, stre                     | et, factory, offic   | СӨ             | 2                           | 8f. Location (Str<br>City or Town   | reet and Number or F            | Rural Route Number,                                 |
|                     | ital o<br>rrs aft<br>ral Di<br>led ir  |                 |   |  |  |  |                |                             |   |                                 |   |
|                     | a Hospital or At<br>24 hours after o<br>a Funeral Directetely filled in by                                     | edicai          | 29a. Certifier 1 Certifying Phys  | icien: To the best of my ler: On the basis of exam | knowledge, death<br>ination and/or inv | occurred at the  | e time, da     | te and place, a             | nd due to the ca  | use(s) and manner a             | s stated.   |
|                     | To the Hospital or within 24 hours after To the Funeral Dir completely filled in                               | Med             | one) 29b. Signature and title of certifier  | and manner stated.                                 |  | on and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  ( 29c. License number 29d. Date signed (Month, Day, Year) |                |                             |   |                                 |   |
|                     | 2  |                 | 16 om   | PO 01  |  | 1  | 2.100 HUIII    | 11411                       | 25  | od. Date signed (Mon            | ur, Day, rear)                                      |
|                     | $\sim$   | -               | 30. Name and address of person who con  | mpleted cause of death (I                          | tem 23a) (Type 9                       | Print)   | 72,            | 7711                        | 1   | tecember                        | 14,2005   |
|                     | nes  |                 | Beverly M. Calk   | 108 m 1) C   | 500 Mon                                |  | Aveni          | Je Ca                       | nbortan   | - ambi                          | 2150  |
|                     | Sta  |                 | 31. Date filed (Month, Day, Year)   | 32. Registrar's Sig                                | gnature                                |  | INC. 11        | <del>√</del> , <u>√</u> ∪ , | · · · · · · · · · · · · · · · · · · ·   | N , III C                       | 2130 8  |
|                     | Registra   | ar              | DEC 1 6 200   | 5  | 19                                     | me   |                |                             |   |                                 |   |

Gomer, Mildred V.

|                     |   |                  | 1- For State Registrar  | State of Ma   |                             | d / Depa                              |   | Health and                                | -                                    | lygien                                   | е                                       |   |
|---------------------|---|------------------|---|---|-----------------------------|---------------------------------------|---|---|--------------------------------------|--|---|---|
|                     | Physic<br>/Medi   | cal              | Decedent's Name (First, Middle, La Mildred V. Gomer  4a. Facility Name (If not institution, give  |   |                             |                                       |   |   | 2. Date of I<br>Month                | ber                                      | 14, 200°                                |   |
|                     | Exami   | ner              | Lions Manor Nursing   |   |                             |                                       |   | or Location of Dea<br>Cumberlan           |                                      | 1  | c. County of Dea<br><b>llegany</b>      | ath   |
|                     | Funeral<br>Director   |                  | 5. Social Security Number 6. S  | ex 7. Ag  | e (In yrs. la               | ast birthday)<br>Yrs.                 | If Under 1 Year<br>Months Days                        | r If Under 24 Hrs                         | 8. Date of B                         | Birth<br>Day, Year                       | 9. Bi                                   | rthplace (State or Foreigr<br>ountry)<br>yland        |
|                     | Maryland<br>I-f ahow  | tor              | 10a. State 10b. County  Maryland Allegar  | nv  | 10c. City,                  | , Town or Lo                          | cation  |   |                                      |  |   | 10d. Inside City Limits 1 ☐ Yes 2 No                  |
|                     | n with the<br>3a or 28s   | I Director       | 10e. Street and Number 10633 Ne   |   | 1                           |                                       | 10f. Zip Code 21532-                                  |   | -                                    | 10g. C                                   | itizen of What C                        | ountry?   |
| 036                 | permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or Items 23a or 28a-f ahow any injury or other traumatic avant. Ire Modical Evanting must be notified at Once. | by Funeral       | 11. Marital Status  1 Never Married 2 Married  3 Nover 4 Divorced   | 12. Was Decedent Armed Forces? 1  Yes 2 1 If Yes, Give Year or Dates: |                             |                                       |   | Hispanic Origin? (Span, Mexican, Puer     | Specify Yes or I<br>to Rican, etc.)  |  | 14. Race - Am<br>Black, Whi<br>Specify: | te, etc.  |
| Maryland 21215-0036 | iithin 72 h<br>ne.<br>nan "natu<br>e Madical  | Completed by     | 15. Decedent's Ed<br>(Specify only highest gra<br>Elementary/Secondary (0-12)   | de completed) College (1-4or 5  | 5+)                         | (Give<br>life. L                      | DO NOT use retire                                     | during most of wo                         | nking                                |  | Kind of Business                        |   |
| 22                  | filed w<br>Hygier<br>othar th   | Col              | 8 0<br>17. Father's Name (First, Middle, Last)  |   |                             | homem                                 | aker  | 18. Mother's Na                           | mo /First Midd                       |  | emaker                                  |   |
| ylan                | should be and Mental a marked o   | To Be            | Frank Jacob Lashbau   | gh  |                             |                                       |   | Minnie M                                  | lissora Ei                           | sler                                     | ,                                       |   |
|                     | and 2 sh<br>ealth and<br>n 27 la m  |                  | 19a. Informant's Name/Relationship ( Larry W. Gomer, Sr.  | Турө, Print)<br>SON   |                             | 16 Gree                               | n Street  |   | ural Route Num<br>stburg             | _  | or Town, State,<br>[aryland             | Zip Code)<br>21532                                    |
| Baltimore,          | Pages 1<br>nent of Hi<br>int: If itar   |                  | 20a. Method of Disposition  1 → Surial 2 □ Cremation 3 □  1 → 4 □ Donation 5 □ Other (Specify   | Removal from State  |                             |                                       | sition (Name of<br>natory or other pla<br>morial Park |   | Date Dec-2005                        |  | ocation - City or                       | Town, State   |
| Balti               | permit. Pages<br>Department of 1<br>Important: If its<br>any injury or o  |                  | 21. Signature of Funeral Service Licer  | Nur   | it                          | 22                                    | . Name and Addre                                      |   |                                      |  |   |   |
|                     | Physician<br>/Medical<br>Examiner   |                  | 23a. Party. Enter the disease, or company spock, or heart failure. List only immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions. | Due to (or as   | a conseque                  | Azute                                 | er the mode of dyi                                    |   | c or respiratory                     | arrest,                                  | -<br>571,                               | Approximate Interval Between Onset and Death 30 mg mb |
| 68/60,              | eath certificate be executed attending physician and for use as the burial-transit  | dical Examiner   | Sequentially list conditions, than, leading to immediate cause. Enter Underlying Cause (Disease or injury that intitated events resulting in death) Last                    | cDue to (or as a  |                             |                                       |   |   |                                      |  |   |   |
| O. Box              | requires that the death certifical<br>een signed by the attending phy<br>nould be detached for use as th  | by Physiclan/Med | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown   | 23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown       | 2 Fetal d                   | death 3 🗌                             | Ectopic pregnanc<br>Other (specify)                   | у   |                                      |  | 23d. Date of del<br>Month               | ivery<br>Day Year                                     |
| ds, P               | n requires that the de<br>been signed by the<br>should be detached  |                  | Part II. Other significant conditions of H & Perter   | ontributing to death bu   | ut not result               | ling in the un                        | derlying cause giv                                    | ven in Part I.                            |                                      | tobacco                                  |   | the cause of death?                                   |
| I Hecords,          | sician: The law rec<br>certificate has beel<br>irector, page 2 shou   | Completed        | Demetiq   |   |                             |                                       |   |   | 24a. Wa<br>auto<br>peri<br>1  Yes    | s an<br>opsy<br>formed?<br>2 <b>X</b> No | prior to death?                         | stopsy findings available completion of cause of      |
| VITal               | cian:<br>sertific<br>setor,   | Be (             | 25. Was case referred to medical examiner?  | 112-1   |                             |                                       |   | 26. Place of Dea                          |                                      |  | 7 7 100                                 | -24.10  |
| ō                   | Phy<br>this<br>al d   | atlon: To        | 1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending 2 Accident investigation  | Hospital: 1 Inpatien 28a. Date of Injur (Month, Day                   | y 2                         | R/Outpatient<br>8b. Time of<br>Injury | 28c. Injur<br>Wor                                     | 4 Nursing H                               | ome 5 Res<br>28d. Describe           |  | 6 □Other (Spec<br>ry occurred           | city)   |
| DIVISION            | To tha Hospital or Attending P within 24 hours after death. To tha Funaral Diractor: After t completely filled in by the funera   | Certification:   | 3 Suicide 6 Could not be determined   | 28e. Place of Injubulding, etc  | ry - At hom<br>:. (Specify) | e, farm, stre                         | et, factory, office                                   |   | 28f. Location<br>City or To          | (Street ar.<br>own, State                | nd Number or Ru<br>9)                   | ral Route Number,                                     |
|                     | To tha Hospit<br>within 24 hour<br>To tha Funara<br>completely fills  | Medical (        | 29a. Certifier (Check only one) 12 Certifying Phy   | /sician: To the best o<br>iner: On the basis of<br>and manner stat    | examination                 | edge, death<br>n and/or inve          | occurred at the tir<br>estigation, in my o            | me, date and place<br>opinion, death occu | , and due to the<br>rred at the time | cause(s)                                 | and manner as<br>d place, and due       | stated.<br>to the cause(s)                            |
|                     | To t<br>To t  | Σ                | 29b. Signature and title of centiler  | R   |                             |                                       | 29c. Licens   |   |                                      | 1700                                     | te signed (Month                        |   |
|                     | ×   |                  | 30. Name and address of person who  | ompleted aguas of di  | oth /lea- a                 | 20) /T                                |   | 33280                                     |                                      |  | iembe                                   |   |
|                     | カルS   |                  | Sunil Gupta   | MD lea  | 25 Ka                       | ent.                                  | Ave. Ci   | umberlo                                   | ind, N                               | 10                                       | 21502                                   | 3   |
| •                   | Sta<br>Registr  |                  | 31. Date filed (Month, Day 17 ay) DEC 15 200  | 32 Aegistra   | rs Signatur                 | e da                                  | W.  |   | ,                                    |  |   |   |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 005 Certificate of Death 2. Date of Death Month 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** DECEMBER 13, 2005 9:30 P. FRANKLIN GEATZ, JR. NORMAN /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner ALLEGANY CUMBERLAND DEVLIN MANOR NURSING HOME If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex **Funeral** 1**∑**M 2□F 216-22-6235 Director MARYLAND 78 JAN. 24, 1927 Usual Residence of Decedent deeth with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10b. County Item 27 is marked other then "neturel", or Iteme 23a or 28a-f ehow other traumatic event, the Madical Examinar must be notified at 1 Nes 2 No Director MD ALLEGANY CUMBERLAND 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number 417 MAGRUDER STREET 21502 U.S.A. Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ∑Yes 2 □ No If Yes, Give Year or Dates: WWII Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Importent: if item 27 is marked other then "neturel", or item any injury or other traumatic event, the Medical Examinations. 1 ☐ Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify.WHITE þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) INSURANCE SALESMAN 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be MARGARET ELLIOTT NORMAN FRANKLIN GEATZ, SR. ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 417 MAGRUDER STREET, CUMBERLAND, MD 21502 MARY IRENE GEATZ / WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a, Method of Disposition 1 Durial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) M.S.V.C.-ROCKY GAP 12/19/2005 FLINTSTONE, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility UPCHURCH FUNERAL HOME, P.A. 202 GREENE STREET, CUMBERLAND, MD Macheller 21502 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** NEUMON disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed attending physicien and I for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Completed by Physician/Medical IF FEMALE 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) cete hes been signed by the a page 2 should be detached to ☐Yes 2☐No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2, No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 1 No 1 ☐ Yes 2 2 No To the Hoepital or Attending Physicien: within 24 hours efter death. To the Funerel Director: After this certifice director Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဥ 1 Yes 2 No Director: After the in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1-Natural 5 Pending 1 Yes 2 No 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide determined 4 | Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier INA www 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MAO 31. Date filed (Month, Day, Year) 32. Registrar's Signature State DEC 1 6 2005 Registrar

|                   |  |                  | For   | State of N                                   | Maryland                          | / Depa                    | artmen                              | t of H                  | ealth a                    |                           | -                                       |           | o E  | 1016  |
|-------------------|--|------------------|---|--|-----------------------------------|---------------------------|-------------------------------------|-------------------------|----------------------------|---------------------------|---|-----------|--|---|
|                   |  |                  | State Registrar   |  |                                   | Ce                        | rtificate                           | e of L                  | Death                      |                           |   | eg, No    | Ub   | 41940   |
|                   | Dhysiai  |                  | 1. Decedent's Name (First, Middle, Las  | st)  |                                   |                           |                                     |                         |                            | 1                         | <ol><li>Date of Dea<br/>Month</li></ol> | th<br>Day | Year   | 3. Time of Death                                |
|                   | Physici<br>/Medic<br>Examin  | al               | Elizabeth E. Gree 4a. Facility Name (If not institution, give   |  | er)                               |                           | 4b. City,                           | Town, or                | Location o                 |                           | Decembe                                 |           | 2005<br>County of Death                          | 9:30 A M  |
| 200               |  |                  | Montgomery General  | Hospita                                      | 1                                 |                           |                                     | 0                       | 1ney                       |                           |   |           | Montgom  | nery  |
|                   | Funeral  |                  | Social Security Number     6. S   | ex 7.7                                       | Age (In yrs. las                  | t birthday)<br>Yrs.       | If Under<br>Months                  | 1 Year<br>Days          | If Under a                 | Min.                      | B. Date of Birth<br>(Month, Day         | Year)     |  | nplace (State or Foreign<br>untry)              |
|                   | Director   |                  | 578-26-2384 Supplies the State of December 1  |  | 83                                | 115.                      |                                     |                         |                            | ]                         | May 3,                                  | 1922      | 2   Wash   | nington,DC                                      |
|                   | /land  |                  | 10a. State 10b. County  |  | 10c. City, 7                      | Town or Lo                | ocation                             |                         |                            |                           |   |           |  | 10d. Inside City Limits                         |
|                   | Many<br>a-f sh   | tor              | Maryland Montgome   | ery  |                                   | Silv                      | er Sp                               | ring                    |                            |                           |   |           |  | 1 ☐ Yes 2 ☑ No                                  |
|                   | or 28.   | Funeral Director | 10e. Street and Number  |  |                                   |                           | 10f. Zip                            | Code                    |                            |                           | 1                                       | 0g. Citiz | en of What Co                                    | untry?  |
|                   | 23a  | S.               | 14 Vantage Hill (   |  |                                   |                           |                                     | 209                     |                            |                           |   |           | USA  |   |
|                   | er de  | nue              | 11. Marital Status  | 12. Was Deceder<br>Armed Force               | s?                                | 13.                       | Was Deced<br>II Yes, spec           | dent of Hi<br>cify Cuba | ispanic Orig<br>n, Mexican | gin? (Spec<br>n, Puerto R | ify Yes or No-<br>ican, etc.)           | 1         | <ol> <li>Race - Amer<br/>Black, White</li> </ol> |   |
| 36                | rs aft   | by F             | 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced  | 1 ☐ Yes 2 €<br>If Yes, Give<br>Year or Date: | -                                 |                           | 1 🗌 Yes                             | 2 💢 No                  | Specify:                   |                           |   |           | Specify:   | 1   |
| 21215-0036        | within 72 hours after death with the Maryland<br>ene.<br>then "natural", or items 23a or 28a-f show<br>the Madisal Examiner must be multified at   |                  | 15. Decedent's Ed   | ducation                                     |                                   | 16a. Dece                 | dent's Usua                         | al Occupa               | ation                      |                           |   | 16b. Kin  | M<br>Id of Business/I                            | hite<br>Industry                                |
| 215               | hin 72   | piet             | (Specify only highest gra   | de completed) College (1-4d                  | or 5+)                            | (Give<br>life.            | kind of wo<br>DO NOT us             | rk done d<br>se retired | luring most<br> )          | t of working              | 9                                       |           |  |   |
| 21                | er th  | Completed        |   | 2  |                                   | Hom                       | emake                               | r                       |                            |                           |   |           | Home   |   |
| 밀                 | be filed<br>tal Hygid<br>d other   | Be (             | 17. Father's Name (First, Middle, Last)   |  |                                   |                           |                                     |                         | 18. Mothe                  | r's Name                  | (First, Middle,                         | Maiden S  | Sumame)  |   |
| Maryland          | permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importents if item 27 is marked other then "natural; or items 23a or 28a-f show amy july yo other traumatic event, the Madical Examiner must be notified at an ance. | ၉                | Julius Egloff   |  |                                   | 4.01 - 4.111              |                                     | (2)                     |                            |                           | h Ma                                    |           |  |   |
| Mar               | 12 sh<br>h and<br>7 le m<br>traum  |                  | 19a. Informant's Name/Relationship (  |  |                                   |                           |                                     |                         |                            |                           |   |           | Town, State, Z                                   |   |
|                   | 1 and<br>Health<br>em 27   |                  | Judith E. Iager 20a. Method of Disposition  | Daugh  | 20b. Plac                         | ce of Dispo               | sition (Nar                         | ne of                   |                            | Fulto<br>Da               |   |           | 20759<br>cation - City or                        |   |
| ğ                 | Pages<br>nent of<br>nnt: If it   | ١.               | 1 ☐ Burial 2 ☆Cremation 3 ☐<br>4 ☐ Donation 5 ☐ Other (Specif   | Removal from Sta                             |                                   | netery, cre<br>copo1      | m <i>atory</i> or o<br>i <b>tan</b> |                         | 100                        |                           |   |           | 1 24004  |   |
| Baltimore,        | artme<br>orten<br>injur  | l ii             | 21. Signature of Funeral Service Licer  | isee   |                                   | 2                         | 2. Name an                          | d Addres                | s of Facilit               | v                         |   |           |  | Virginia  |
| Ba                | Departr<br>Importr<br>any inj  | . 31             | Ville Etaon   | esto   |                                   |                           |                                     |                         |                            |                           |   |           | e, Inc.  | land 20901                                      |
| 1                 |  |                  | 23a, Part1. Enter the disease, or com<br>shock, or heart failure. List only                                 | plications that caus                         | sed the death.                    | Do not en                 | ter the mod                         | le ol dyin              | g, such as                 | cardiac or                | respiratory arr                         | est,      | r., mary   | Approximate<br>Interval Between                 |
|                   | Physician  |                  | Immediate Cause (Final disease or condition   | Pyrou  | I IN DIV                          | D'                        |                                     |                         |                            |                           |   |           |  | Onset and Death                                 |
|                   | /Medical   |                  | resulting in death)   | a. Due to (or                                | as a conseque                     | nce of):                  |                                     |                         |                            |                           |   |           |  |   |
|                   | Examiner   |                  | Sequentially list conditions.   | b. Cirv                                      | Mosis                             | 0                         | the                                 | Li                      | Non                        | ·                         |   |           |  |   |
|                   | pe ils   | Examiner         | Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury | Due to (or                                   | as a conseque                     | nce ol):                  | ,                                   |                         |                            |                           |   |           |  |   |
| _                 | and<br>and<br>Il-tran  | хап              | that initiated events<br>resulting in death) Last   | c. Due to (or                                | as a conseque                     | nce ol):                  |                                     |                         |                            |                           |   |           |  |   |
| 760,              | eath certificate be executed attending physicien and for use as the burial-transit   | caiE             | (   |  |                                   |                           |                                     |                         |                            |                           |   |           |  |   |
| 687               | ficate<br>p phys   |                  |   | a  |                                   |                           |                                     |                         |                            |                           |   |           |  |   |
| Box               | n cert   | Physician/Med    | IF FEMALE:<br>23b. Was decedent pregnant  | 23c. If yes, outcor                          | me of pregnance                   |                           | Ectopic pr                          |                         |                            |                           |   | 2         | 3d. Date of deli                                 | ,   |
|                   | death<br>e atte  | lcla             | in the past 12 months?  |  | t at time of dear                 |                           | Other (sp                           |                         |                            |                           |   | - 1       | Month  | Day Year  |
| P.0               | that the death<br>ed by the atte<br>detached for   | hys              | 9 ☐ Unknown   |  |                                   |                           |                                     | _                       |                            | -                         | 1                                       | _         |  |   |
|                   | 8 5 0  | by               | Part II. Other significant conditions of  | contributing to deat                         | h but not resulti<br>ヘ            | ing in the u              | inderlying o                        | ause givi               | en in Part I.              |                           |   |           |  | the cause of death?                             |
| ord               | w require<br>been sig<br>should b  | ted              | LIEMAI EX   | 402100                                       |                                   |                           |                                     |                         |                            |                           | 1014                                    | es 2      | No 3∏Pro   | ODADRY 4 ONKNOWN                                |
| Records,          | has b  | Completed by     |   |  |                                   |                           |                                     |                         |                            |                           | 24a. Was a<br>autops                    | SY        |  | topsy lindings available completion of cause of |
|                   |  | ပိ               |   |  |                                   |                           |                                     |                         |                            |                           | perfor<br>1 Yes                         | No        | 1 Yes  | 2 No  |
| Division of Vital | Physician:<br>this certific<br>ral director,   | Be               | 25. Was case referred to medical examiner?  | Hospital:                                    |                                   |                           |                                     | Oth                     | or                         |                           | (Check only or                          |           |  |   |
| ō                 | Phys<br>r this<br>ral di   | . To             | 1 Yes 2 40  | 28a. Oate of I                               |                                   | R/Outpatie<br>28b. Time o |                                     | 28c. Injun              | y at                       |                           | ie 5∐Resid<br>8d. Describe h            |           | Other (Spec                                      | cify)   |
| O                 | Attending in death.  | tion             | Natural 5 Pending 2 Accident investigatio   |  | Day Year)                         | Injury                    | м                                   | Worl                    | k?<br>Yes 2 🔲              | No                        |   |           |  |   |
| Visi              | Atter<br>r dea<br>ector<br>by the  | Hice             | 3 Suicide 6 Could not b   | 200. Flace 01                                | Injury - At hom<br>etc. (Specify) |                           | reet, factor                        | y, office               |                            | 2                         | 81. Location (S<br>City or Tow          |           |  | ıral Route Number,                              |
| Ö                 | s afte   | Certification:   | 4 D Honnoide  | bullaing,                                    | , etc. (Specify)                  |                           |                                     |                         |                            |                           | City of Yow                             | r, State) |  |   |
|                   | To the Hospitel or Attending Ph<br>within 24 hours after death.<br>To the Funerel Director: After th<br>completely filled in by the funeral  |                  | (Check only 2 Medical Exam  | nysicien: To the be<br>miner: On the basi    | s of examinatio                   | ledge, dea                | th occurred                         | at the tin              | ne, date an<br>pinion, dea | id place, a               | nd due to the o                         | ause(s)   | and manner as<br>place, and due                  | stated.<br>to the cause(s)                      |
|                   | the I  | Medical          | one) 29b. Signature and title of certifier  | and manner                                   | stated.                           |                           |                                     |                         | e number                   |                           |   |           | signed (Mont)                                    |   |
|                   | V 5 ₹ 5 8  |                  | SSS. Signatura dan tra di carina  | 0 4 -  |                                   |                           | 250                                 | 1                       | 012                        | 219                       | 1                                       | 12        | Vala   |   |
|                   | 10   |                  | 30. Name and address of person who  | completed cause                              | ol death (Item 3                  | 23a) /Tupo                | Print\                              |                         | 06                         | ) I L                     | 0                                       | 10        | 1110   | )   |
|                   |  |                  | Matthew C M   | Andre  | W 1º                              | 8101                      |                                     | uce                     | Phi                        | Lip                       | Driv                                    | ام        | Olue   | 4 HD 208  |
|                   | Sta<br>Regist  | ate<br>rar       | 31. Date filed (Month, Day, Year) DEC 12  | 2005   | istrar's Signatu                  | F 19                      | mente.                              |                         | •                          | 1                         |   |           |  | 1   |

|       |                            |  |                   | For State Registrar   | State of   | Marylan  |                                | rtment of                              | Health and I                               | Mental Hy                             | giene                          | )5                        | 41947  |
|-------|----------------------------|--|-------------------|---|--|--|--------------------------------|--|--|---------------------------------------|--------------------------------|---------------------------|--|
|       | Up                         | * × ,  |                   | Decedent's Name (First, Middle, I   | Last)  |  |                                |  |  | 2. Date of De                         | ath                            |                           | 3. Time of Death                                   |
|       |                            | Physici  |                   | LEROY   | 7  | HAR  | Dis                            |  |  | Month                                 | Day 14 2                       | Year<br>2005              | 0245 A M   |
| ~     |                            | /Medio<br>Examin   |                   | 4a. Facility Name (If not institution, g  | rive street and numb                                   |  |                                | 4b. City, Town,                        | or Location of Deatl                       |                                       | 4c. County                     |                           | 1  |
|       |                            | Exami  | iei               | Memorial He   | 11   | at Ea  | Kloo                           | Fas                                    | ston                                       |                                       | To                             | 11                        | +  |
|       | No                         | Funeral  | 7.                |   | . Sex 7.   | . Age (In yrs. I   | ast birthday)                  | if Under 1 Year                        | r If Under 24 Hrs.                         | 8. Date of Bir                        | th                             |                           | lace (State or Foreign                             |
|       |                            | Director   |                   | 218-20-6478   | 1 <b>X</b> M 2□F                                       | 79   | Yrs.                           | Months Days                            | Hours Min.                                 | Dec. 14,                              | 1926                           | Penn                      | sylvania   |
|       |                            | 4  |                   | Usual Residence of Decedent   |  |  |                                |  |  | , , , , , , , , , , , , , , , , , , , | 2320                           | 1 CIII                    | BATAULT  |
|       |                            | how  |                   | 10a. State 10b. County  |  | 10c. City  | , Town or Loc                  | cation                                 |  |                                       |                                | 11                        | 0d. Inside City Limits                             |
|       |                            | death with the Maryland<br>ms 23a or 28a-f show<br>rmust be notified at  | tor               | Maryland Caroli   | ne   | Ri   | dgely                          |  |  |                                       |                                |                           | 1 ☐ Yes 2 ☑,No                                     |
|       |                            | h the  | Director          | 10e. Street and Number  |  |  | -0/                            | 10f. Zip Code                          |  |                                       | 10g. Citizen of V              | Vhat Coun                 | itry?  |
|       |                            | 1h wil   | al                | 11394 Holley  | Road   |  |                                | 21660                                  | )  |                                       | USA                            |                           |  |
|       |                            | dea  | Funeral           | 11. Marital Status  | 12. Was Deced  |  | S. 13. V                       | Vas Decedent of                        | Hispanic Origin? (S<br>ban, Mexican, Puert | pecify Yes or No                      | - 14. Rac                      | e - Americ                |  |
|       | 9                          | or its   |                   | 1 Never Married 2 Married   | 1 1 TYes 2<br>If Yes, Give                             | . □ No   | 1                              | ☐ Yes 2 No                             |  |                                       | Specify                        |                           |  |
| ()    | 5-0036                     | within 72 hours after<br>6ne.<br>than "naturel", or ite  | d by              | 3 Widowed 4 Divorced  | Year or Date   | es:  | ,                              |  | operny.                                    |                                       | Зреспу                         | . 'BT                     | ack  |
| 1.1   | 5-(                        | 72 h<br>'natu  | Completed         | 15. Decedent's<br>(Specify only highest of  | Education<br>grade completed)                          |  | (Give l                        | ent's Usual Occu                       | e during most of wor                       | rking                                 | 16b. Kind of Bu                | ısiness/Ind               | dustry   |
| 7     | 2121                       | ithin  | npi               | Elementary/Secondary (0-12)   | College (1-4   | tor 5+)  |                                | O NOT use retire                       |  |                                       |                                |                           |  |
| 0     | <b>5</b>                   | ied w<br>lygie<br>her ti   | S                 | 6   |  |  | Truck                          | Drive                                  | T  | - /pm;                                |                                | Trucl                     | king   |
| Q     | Ē                          | tal H  | Be                | 17. Father's Name (First, Middle, La  |  |  |                                |  |  |                                       | , Maiden Sumam                 | Θ)                        |  |
| 7     | yla                        | ould<br>Men<br>Men<br>arka   | ဥ                 | Leroy McGlotte  |  |  |                                |  | Pearl                                      | Harris                                |                                |                           |  |
| 5     | altimore, Maryland         | 12 should be filed within hand Mental Hygiene. 7 is marked other than "reaumatic event, tre Mes  |                   | 19a. Informant's Name/Relationship  | (Type, Print)  |  |                                |  | et and Number or Ru                        |                                       |                                | State, Zip                | Code)  |
| arris | 2                          | of Health<br>Item 27 i   |                   | Robin Rankins /   | <u>Daughter</u>  |  |                                |  | Ridgely,                                   |                                       |                                |                           |  |
| 5     | Ore                        | H ite  |                   | 20a. Method of Disposition 1 ABurial 2 ☐ Cremation 3  | ☐Removal from St                                       | ate 200. P   | ace of Dispos<br>emetery, crem | sition (Name of<br>natory or other pla | ace)                                       | Date                                  | 20c. Location -                | City or To                | wn, State  |
| 0     | Ë                          | Pag<br>men<br>tant:<br>jury  |                   | 4 Donation 5 Other (Spec  |  | Mat  | ryland                         | Veteran                                | is   12-1                                  | 9-2005                                | Hurlock                        | ,Mar                      | yland  |
| +     | Bal                        | permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturel", or items 23a or 28a-f show any injury or other traumatic event, the Medical Exeminar must be notified at once. |                   | 21 Signature of Funeral Service Lic   | Эрего  | N  | 22.<br>I                       | Name and Addr<br>Bennie S              | ress of Facility<br>mith Fune              | ral Hom                               | e                              |                           |  |
|       |                            | or □ ≒ a o   |                   | Stanog  | Del  |  |                                |  | mith Fune<br>r Street,                     |                                       |                                | 2160                      |  |
|       |                            |  |                   | 23a. Part1. Enter the disease, of co<br>shock, or heart failure. List on                                    | implications that cau<br>ily one cause on eac          | used the death<br>ch line.   | n. Do not ente                 | er the mode of dy                      | ring, such as cardiac                      | or respiratory a                      | rrest,                         |                           | Approximate<br>Interval Between<br>Onset and Death |
| 4     | Anna                       | Physician  |                   | Immediate Cause (Final disease or condition   | - Pray   | nonio  | A                              |  |  |                                       |                                |                           | Oriset and Death                                   |
|       |                            | /Medical   |                   | resulting in death)   | Due to (or   | r as a consequ   | uence of):                     |  |  |                                       |                                |                           |  |
| ,     |                            | Examiner   | ١. ا              | Sequentially list conditions.   | b. main  | いかいた   | 20                             | -                                      |  |                                       |                                |                           |  |
|       |                            | P =  | ine               | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | Dua to (or   | الم المادة المادة المادة المادة المادة المادة المادة المادة المادة المادة المادة المادة المادة المادة المادة ا | aerius vi).                    |  |  |                                       |                                |                           |  |
|       |                            | executed<br>in and<br>ial-transi   | Examiner          | that initiated events resulting in death) Last  | · mea  | Static   | PC                             | State                                  | cancer                                     |                                       |                                |                           |  |
|       | 50,                        | be ex<br>icien a<br>burial   |                   | Todaking in South Last  | Due to (or   | r as a consequ   | Jence or):                     |  |  |                                       |                                |                           |  |
|       | 8760,                      | 9 %  | Physician/Medical |   | d  |  |                                |  |  |                                       |                                | -                         |  |
|       | Box 6                      | leath certificate<br>attending phys  | Me                | IF FEMALE:  | 00- 11   |  |                                |  |  |                                       |                                |                           |  |
|       | 30)                        | death o  | ian               | 23b. Was decedent pregnant in the past 12 months?   |  | th 2 Fetal   | death 3                        | Ectopic pregnanc                       | су   |                                       | 23d. Dat<br>Mor                | e of delive               | ry<br>Day Year                                     |
|       | 0                          | the a  | /sic              | 1 ☐ Yes 2 ☑ No<br>9 ☐ Unknown   | 4∐Pregnar<br>9□ Unknow                                 | nt at time of de<br>vn   | eath 5∐                        | Other (specify) _                      |  |                                       |                                |                           | ,  |
|       | P.O.                       | a y  |                   | Part II. Other significant conditions   | s contributing to dea                                  | th but not resu  | ulting in the un               | derlying cause a                       | wen in Part I                              | 23e Did                               | obacco use contr               | ribute to th              | e cause of death?                                  |
|       | S,                         | ires tha<br>signed<br>be det   | by                | cerebro-Vuscoli   |  |  | and at the on                  | donying caddo g                        | TVOIT IIT I GITT.                          |                                       |                                |                           | ably 4 □Unknown                                    |
|       | 5                          | w requires<br>been sign<br>should be   | etec              | CERCONS-VINSCON   | MY May   | (XEVI)   |                                |  |  |                                       | 703 2 110                      |                           |  |
|       | ec                         | 8 8  | Completed         |   |  |  |                                |  |  | 24a. Was<br>auto                      | an 24b. V                      | Vere autor                | osy findings available inpletion of cause of       |
|       | =                          | : The cate h   | Sol               |   |  |  |                                |  |  | 1 ☐ Yes                               | ormed? d                       | Yes                       | 2 No   |
|       | /ita                       | Physician: The lav<br>this certificate has<br>ral director, page 2   | Be                | 25. Was case referred to medical examiner?  | Hospital   |  |                                | 100                                    | 26. Place of Dea                           |                                       |                                |                           |  |
|       | of                         | hysi<br>this c   | ဥ                 | 1 Yes 2 No  | Hospital:  |  | ER/Outpatient                  | JU DON                                 |  |                                       | dence 6 Othe                   |                           | )  |
|       | U C                        | After<br>uner  | on                | 27. Manner of Death 1 ☑Natural 5 ☐ Pending  | 28a. Date of<br>(Month,                                | Day Year)  | 28b. Time of<br>Injury         | 28c. Inju                              |  | 28d. Describe                         | how injury occurr              | ed                        |  |
|       | Sic                        | tend<br>death<br>tor:  | cat               | 2 Accident investigat 3 Suicide 6 Could not   | he   | A ledius - AA ba   |                                |  | Yes 2 □No                                  | 004                                   |                                |                           |  |
|       | Division of Vital Records, | or Al  | Certification:    | 4 ☐ Homicide determine  | ad 286. Place of building                              | g, etc. (Specify   | me, rarm, stre                 | et, factory, office                    | •  | City or To                            | Street and Numbe<br>vn, State) | er or Hurai               | I Houte Number,                                    |
|       |                            | To the Hospital or Attending Physician: The I within 24 hours after death.  To the Funaral Director: After this certificate ha completely filled in by the funeral director, page  |                   | 29a. Certifier 1 Certifying   | Physician Tether                                       | and of my key  | uladaa daabh                   |  |  |                                       |                                |                           |  |
|       |                            | Hos<br>24 ho<br>Fun<br>stely   | edical            |   | Physician: To the b<br>aminer: On the bas<br>and manne | is of examinat   | ion and/or inv                 | estigation, in my                      | opinion, death occu                        | rred at the time,                     | date and place, a              | nner as sta<br>and due to | ated.<br>the cause(s)                              |
|       |                            | ithin<br>o the   | Me                | 29b. Signature and title of certifier   | and manno  | ii statou.   |                                | 29c. Licen                             | nse number                                 |                                       | 29d. Date signed               | (Month, I                 | Dav. Year)   |
|       |                            | 8 4 € 4  |                   | Maile C   | . Mam  |  |                                | 1                                      | 59762                                      |                                       | 12/14/05                       |                           |  |
|       |                            |  |                   | 20 Name and addison of some   | o completed assist                                     | of dooth (tra-   | 220) (7: 5                     | Print)                                 |  |                                       |                                |                           |  |
| 1     | (5                         | +IVA)  |                   | 30. Name and address of person wh   | Completed cause  |  | 23a) (Type, F                  | MA 2                                   | 1601                                       |                                       |                                |                           |  |
|       | 1                          | Sta  | te                | 31. Date filed (Month, Day, Year)   | 1,10   | gistrar's Signar   |                                |  | ,  |                                       |                                |                           |  |
|       | 1                          | Registr  |                   | UE.   | 7 700 100  |  | De So                          | 1                                      |  |                                       |                                |                           |  |

|            |  |                | For<br>State<br>Registrar  | State of                                      | Marylar                      |                                   | artment of H<br>rtificate of L                               |                |                    | tal Hygie                          | HIII                 | 41948  |
|------------|--|----------------|--|---|------------------------------|-----------------------------------|--|----------------|--------------------|------------------------------------|----------------------|--|
|            | Div. dat   |                | 1. Decedent's Name (First, Middle  | , Last)                                       |                              |                                   |  |                |                    | ate of Death                       |                      | 3. Time of Death   |
|            | Physici<br>/Medic  |                | Vernon   |   | Willis                       | Hen                               | ndrickson  |                | _                  | ember 9.                           | Day Year<br>2005     | 4:48 P M   |
|            | Examir   |                | 4a. Facility Name (If not institution  | , give street and num                         | iber)                        |                                   | 4b. City, Town, or   | Location       | n of Death         |                                    | 4c. County of Dea    |  |
| ı          |  |                | Memorial Hos   | pital   |                              |                                   | Cumber   | rland          | l                  |                                    | Allegan              | nv   |
|            | Funeral  |                | 5. Social Security Number  |   | 7. Age (In yrs.              | **                                | If Under 1 Year<br>Months Days                               | If Unde        |                    | ate of Birth<br>Month, Day, Ye     |                      | rthplace (State or Foreign ountry)   |
| L          | Director   |                | 217-28-7778  | 1⊠M 2□F                                       | 76                           | Yrs.                              |  | 110010         |                    | /05/1929                           |                      | nsylvania  |
|            | pur *  |                | Usual Residence of Decedent  10a. State 10b. County                                |   | 10c Cit                      | ty, Town or Lo                    | cation   |                |                    |                                    |                      | 10d. Inside City Limits  |
|            | lanyli   | ក              | PA Bedfor  | A   |                              |                                   |  |                |                    |                                    |                      | 1 Yes 21 No  |
|            | 28a-1  | Director       | 10e. Street and Number   | <u> </u>                                      |                              | Crear                             | ville  |                |                    | 10                                 |                      |  |
|            | with a or  | ត់             |  | intstone Cre                                  | ole Dood                     |                                   | 10f. Zip Code  | 1550           | · E                | 10g.                               | Citizen of What C    | ountry?  |
|            | eath   | eral           | 11. Marital Status   | 12. Was Dece                                  |                              | 18 12 1                           | Mas Dandont of Hi  | <b>1</b> 553   |                    | Y = = = 1   = =                    | USA<br>14. Race - Am | litera festas  |
| 21215-0036 | iges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene.  If item 27 is marked other than "natural", or Items 23a or 28a-f show or other traumatic evant, the Medical Examinational to Italian at | by Funeral     | 1 ☐ Never Married 2 ☑ Marr<br>3 ☐ Widowed 4 ☐ Divorced                             | Armed For                                     | ces?<br>2 ⊠ No               |                                   | Vas Decedent of Hi<br>f Yes, specify Cubai<br>I □ Yes 2፟፟ No | n, Mexic       |                    | n, etc.)                           | Black, Whi           |  |
| Ö          | 2 ho   | Completed      | 15. Deceden  | 's Education                                  |                              |                                   | lent's Usual Occupa  |                |                    | 166                                | . Kind of Business   |  |
| 21,5       | within 7<br>iene.<br>'than "n  | ple            | (Specify only highes<br>Elementary/Secondary (0-12)                                | College (1-                                   | 4or 5+)                      | life. L                           | kind of work done d<br>OO NOT use retired,                   | during mo<br>) | ost of working     |                                    |                      |  |
| 2          | d wil  | Г              | 8  |   |                              |                                   | Laborer  |                |                    |                                    | Lumber               |  |
| nd         | be filed<br>tal Hygid<br>d other<br>evant,   | Be (           | 17. Father's Name (First, Middle,  | Last)   |                              |                                   |  | 18. Mot        | her's Name (Firs   | st, Middle, Mai                    | den Sumame)          |  |
| Maryland   | 2 should be<br>and Mental<br>Is marked or<br>raumatic ev   | 일              | John Wi  | llis  | Hendr                        | ickson                            |  | Не             | len                | Rosan                              | nah Ri               | ice  |
| ar         | 2 sho<br>and<br>Ism  | 7              | 19a. Informant's Name/Relations  |   |                              | 2                                 | g Address (Street a  |                |                    |                                    |                      | . ,  |
|            | 1 and 2<br>Health<br>em 27 I   |                | Helen L. Hendrick  | son / wife                                    |                              |                                   | intstone C   | reek           |                    | arville,                           | Pennsylvar           | nia 15535  |
| altimore,  | ges 1<br>r of H<br>if ite  |                | 20a. Method of Disposition 1    Burial 2 □ Cremation                               | 3 □Removal from S                             |                              | Place of Dispos<br>cemetery, cren | sition (Name of<br>natory or other place                     | θ)             | Date               | 200                                | . Location - City or | Town, State  |
| Ë          | Pagiment<br>ment<br>tant:<br>jury o  |                | ' 4 □Donation 5 □ Other (S)  |   |                              | 0.0.F. (                          | Cemetery   | j              | 12/12/200          | 05                                 | Flintstone,          | Maryland   |
| Ball       | permit. Pages 1 an<br>Department of Heal<br>Important: If item 2<br>any injury or othar<br>once.   |                | 21. Signature of Funeral Service   | Licensee                                      |                              |                                   | . Name and Addres  |                | ridding            |                                    | Funeral Hom          |  |
|            | 0.00 = e o   |                | Kelet (  | - Hole  |                              |                                   | 404 Decatur  |                |                    |                                    |                      | 21502  |
|            |  |                | 23a. Part1. Enter the disease, or shock, or heart failure. List                    | complications that ca<br>only one cause on ea | used the deat<br>ch line.    | h. Do not ente                    | er the mode of dying   | g, such a      | as cardiac or resp | piratory arrest,                   |                      | Approximate<br>Interval Between  |
|            | Physician  | S Y            | Immediate Cause (Final disease or condition resulting in death)                    | _aArte  | rioscler                     | otic Hes                          | rt Disease   |                |                    |                                    |                      | Onset and Death  |
|            | /Medical<br>Examiner   |                | resulting in death)  |   | r as a conseq                |                                   |  |                |                    |                                    |                      | The state of the s |
| В          |  | -              | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying | b. Due to (c                                  | r as a conseq                | uence of):                        |  |                |                    |                                    |                      |  |
|            | nsit   | Examiner       | Causa (Discasa of injury   |   |                              | 30,,00 01,                        |  |                |                    |                                    |                      |  |
| ,          | icate be executed<br>physician and<br>s the burial-transit   | Хаі            | that initiated events<br>resulting in death) Last                                  | C. Due to (c                                  | r as a conseq                | uence of):                        |  |                |                    | _                                  |                      |  |
| 8760,      | siciar<br>siciar<br>buri   | dical          |  |   |                              |                                   |  |                |                    |                                    |                      |  |
| .89        | flicate<br>p phy<br>as the   | edic           |  | 0.  |                              |                                   |  |                |                    |                                    |                      |  |
| Box        | The law requires that the death certificate has been signed by the attending page 2 should be detached for use as  | Physician/Me   | IF FEMALE:<br>23b. Was decedent pregnant   | 23c. If yes, outc                             |                              |                                   |  |                |                    |                                    | 23d. Date of de      | livery   |
|            | death<br>e atte<br>d for   | Cta            | in the past 12 months?   | 4□Pregna                                      | th 2∏Feta<br>nt at time of d |                                   | Ectopic pregnancy<br>Other (specify)                         |                |                    |                                    | Month                | Day Year   |
| o.         | that the de<br>led by the a<br>detached f  | hys            | 9 Unknown  | 9□ Unknov                                     | ₩n                           |                                   |  |                |                    |                                    |                      |  |
| ر.<br>ت    | ned t  | by P           | Part II. Other significant condition   | ns contributing to dea                        | ath but not res              | ulting in the un                  | derlying cause give  | n in Part      | t J. 2             | 3e. Did tobaco                     | co use contribute to | the cause of death?  |
| Records,   | w requires<br>been sign  | pe pe          | Carcinoma-unkno  | own primary                                   |                              |                                   |  |                |                    | 1 🗀 Yes                            | 2 □ No 3 □ Pr        | robably 4 Munknown   |
| CO         | aw requisible been   | Completed      |  |   |                              |                                   |  |                | 2                  | 4a. Was an                         | 24b. Were at         | utopsy findings available  |
| Be         | The la   | E O            |  |   |                              |                                   |  |                |                    | autopsy<br>performed               | ? prior to death?    | completion of cause of   |
| Vital      |  | 0              | 25. Was case referred to medical   |   |                              |                                   |  | 26 Plac        | ce of Death (Che   | Yes 2X                             | No 1 L Yes           | 2 No   |
| $\geq$     | 99 (7) =   | 0 8            | examiner?<br>—1 Ä Yes 2 □ No   | Hospital: 1 🗆 In                              | patient 2K                   | ER/Outpatient                     | 3□ DOA Othe  |                |                    |                                    | 6 ☐Other (Spe        | cihi)  |
| o t        | ding Phy<br>h.<br>After this<br>funeral c  | n: T           | 27. Manner of Death  | 28a. Date of                                  | Injury                       | 28b. Time of                      | 28c. Injury  | at             |                    | escribe how in                     |                      | City   |
| ō          | Attending I<br>r death.<br>ector: After<br>by the funer  | atlo           | 1 X Natural 5 ☐ Pending<br>2 ☐ Accident investig                                   | ,   | , Day Year)                  | Injury                            | M 1 🗆 Y  | ./<br>′es 2.[  | □No                |                                    |                      |  |
| Division   | or Attene<br>after death<br>Director:<br>in by the   | Certification: | 3 ☐ Suicide 6 ☐ Could n<br>4 ☐ Homicide determi                                    | ned 288. Place o                              | of Injury - At ho            | ome, farm, stre                   | et, factory, office  |                | 28f. Lc            | ocation (Street<br>ity or Town, St | and Number or Ru     | ural Route Number,   |
|            | s after sall Direction by  | Cer            |  | Danami  | g, etc. (opecn)              | "                                 |  |                |                    | ny or rown, st                     | a(e)                 |  |
|            | To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by   |                | 29a. Certifier 1 ☐ Certifying (Check only 2 🕅 Medical E                            | g Physician: To the base                      | est of my kno                | wiedge, death                     | occurred at the time   | e, date a      | and place, and du  | ie to the cause                    | e(s) and manner as   | stated.  |
|            | To the H<br>within 24<br>To the F<br>complete  | Medical        | 5110)  | and manne                                     | or stated.                   |                                   | oougation, in my op  | iiiloii, de    | au occurred at t   | ne time, date :                    | and place, and due   | to the cause(s)  |
|            | To the<br>within<br>To the<br>comple   | 2              | 29b. Signature and title of certifier  |   |                              |                                   | 29c. License   | number         | •                  | 29d.                               | Date signed (Mont    | h, Day, Year)  |
| ł          | 6  |                | 10 aul   | Me  | <u> </u>                     |                                   | D09  | 9157           |                    |                                    | December 10          | 2005   |
|            | MUS  |                | 30. Name and address of person v   |   |                              |                                   | Print)   |                |                    |                                    |                      | <del>,</del>   |
|            |  |                | Paul Snow, M   | .D., 124 We                                   | st Third                     | Street,                           | Cumberlano   | d, Ma          | ryland 21          | 1502                               |                      |  |
|            | Sta  | -              | 31. Date filed (Month Day, Year)   | 005 37 Re                                     | gistrar's Signa              | ure for                           | alle)  |                |                    |                                    |                      |  |
|            | Registra   | a)             |  |   | W. C.                        | 1 ogra                            |  |                |                    |                                    |                      |  |

|            |  |                     | 1 - For State Registrar  | State of Ma  |   | artment of H  |                                | nd Mental Hy                                 | giene<br>Reg. No. () ()                 | 1949   |
|------------|--|---------------------|--|--|---|---|--------------------------------|--|---|--|
|            | Physici  | an                  | Decedent's Name (First, Middle, La   |  |   |   |                                | 2. Date of De.<br>Month                      | Day                                     | 3. Time of Death                                     |
|            | /Media   | al                  | Martha E. Hardy  4a. Fecility Name (If not institution, giv  |  |   | 4b. City, Town, o   | v Location of                  | Decen  | 40, County of                           | 11 Z 11  |
|            | Examir   | ier                 |  | 0 WM   |   | Berl  | Fimo                           |  | But                                     | timore.  |
|            | Funeral  |                     | Social Security Number 6. S  |  | (In yrs. last birthday                          | If Under 1 Year<br>Months Days                                  | If Under 24                    | 4 Hrs. 8. Date of Birt                       | th Yearth C                             | 9. Birthplace (State or Foreign                      |
|            | Director   |                     | 210 30 7320  | □ M 2 💢 F  | 89 Yrs.   | World Days  | Hours                          | Min. JMTy 30                                 | 7, 1916                                 | Pennsylvania   |
|            | and  |                     | Usual Residence of Decedent  10a. State 10b. County  |  | 10c. City, Town or L<br>Baltim                  | ocation   |                                |  | · · · · · · · · · · · · · · · · · · ·   | 10d. Inside City Limits                              |
|            | Maryl<br>f sho   | jo                  | Maryland Baltimor  | e  | Baltim  | ore   |                                |  |   | 1 Yes 2 No   |
|            | h with the<br>23a or 28a<br>st be notified   | ai Direc            | 10e. Street and Number<br>709 Maiden Choice  | Lane   |   | 10f. Zip Code   | 21228                          |  | 10g. Citizen of Wh<br>United S          | nat Country?<br>tates                                |
| 36         | s 1 and 2 should be filed within 72 hours after death with the Maryland I Health and Mental Hyglene. If then 27 is marked other than "naturel; or items 23s or 28s-f show other treumatic event, the Madical Example and the notified at | by Funeral Director | 11. Marital Status  1 □ Never Married 2 □ Married  3 ※Widowed 4 □ Divorced   | 12. Was Decedent II Amed Forces? 1  Yes 2  If Yes, Give Year or Dates: | Ever in U.S. 13.                                | Was Decedent of H<br>If Yes, specify Cub<br>1 ☐ Yes 2 🛣 No      |                                | n? (Specify Yes or No<br>Puerto Rican, etc.) | 14. Race -<br>Black,<br>Specify:        | American Indian,<br>White, etc.<br>White             |
| 9          | 2 hou  | ted                 | 15. Decedent's E   |  | 16a. Dece                                       | dent's Usual Occup  | oation                         | of working                                   | 16b. Kind of Busi                       | iness/Industry                                       |
| 21215-0036 | thin 7.  | Completed           | (Specify only highest grade) Elementary/Secondary (0-12)   | College (1-4or 5   | life.   | edent's Usual Occup<br>e kind of work done<br>DO NOT use retire | d)                             | or working                                   | own h                                   | Omo  |
| 121        | led will have the her the  | Cor                 | 17. Father's Name (First, Middle, Last   |  | 1-4 HOII  | emaker  | 18 Mother                      | s Name (First, Middle,                       |   |  |
| Maryland   | ould be fi<br>Mental It<br>warked of   | To Be               | John H. Bode   |  |   |   | Eliza                          | abeth Ding                                   | gledein                                 |  |
| , Mar      | and 2 sh<br>salth and<br>n 27 is m   |                     | 19a. Informant's Name/Relationship (Frederick Hardy -:   |  | 2904  | Red Lior  | n Lane                         |  | ring, Mar                               | yland 20904  |
| Baltimore, | permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Importent: if item 27 is marked other than 1 any injurge other treumatic event, Item 2006.   |                     | 20a. Method of Disposition 1 ☐ Burial 2 ②Cremation 3 ☐ `4 ☐ Donation 5 ☐ Other (Special  |  | 20b. Place of Disp<br>cemetery, cre<br>Metropol | osition (Name of<br>Impatory or other pla<br>1tan Cren          | natory                         | 12/11/200                                    | 20c. Location · C<br>Alexandr           | ity or Town, State<br>ria, Virginia                  |
| Balti      | permit. Pages<br>Department of<br>Importent: if i<br>any injuges<br>once.  |                     | 21. Signature of Funeral Service Lice  | o Jewas  |   | onald voor  | Bofgwa                         | ardt Funera<br>L Road Beli                   | al Home,<br>tsville,                    | PA<br>Maryland20705                                  |
|            |  |                     | 23a. Part1. Enter the disease, or com<br>shock, or heart failure. List only  | plications that caused<br>one cause on each lin                        | the death. Do not en                            | iter the mode of dyin   | ng, such as c                  | ardiac or respiratory a                      | rrest,                                  | Approximate<br>Interval Between                      |
|            | Pnysician  |                     | Immediate Cause (Final disease or condition  | -a - Do  | emen.   | tia   |                                |  |   | Onset and Death                                      |
|            | /Medical<br>Examiner   |                     | resulting in death)  | Due to (or as  | a consequence of):                              |   |                                |  |   |  |
|            |  | -e                  | Sequentially list conditions, if any, leading to immediate   | b. Due to (or as   | a consequence of):                              |   |                                |  |   |  |
|            | uted<br>d<br>ansit   | Examiner            | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Decrease or whith that initiated events |  |   |   |                                |  |   |  |
| o,         | cate be executed<br>physician and<br>the burial-transit  | Exa                 | resulting in death) Last   | Due to (or as  | a consequence of):                              |   |                                |  |   |  |
| 8760,      | ate be<br>hysicii<br>he bu   | Icai                |  | _ d.   |   |   |                                |  |   |  |
| Box 6      | death certifi<br>e attending<br>id for use as  | Physician/Medical   | IF FEMALE: 23b. Was decedent pregnant in the past 12 months2 1  Yes 2  1  1  | 23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown              | 2 Fetal death 3                                 | □Ectopic pregnanc □ Other (specify) _                           | у                              |  | 23d. Date<br>Monti                      | ,  |
| P,0        | requires that the de<br>een signed by the a<br>nould be detached f   | Ph)                 | Part II. Other significant conditions  | contributing to death b  | ut not resulting in the                         | underlying cause gr   | ven in Part I.                 | 23e. Did to                                  | obacco use contrib                      | ute to the cause of death?                           |
| ds,        | 90   | d by                | •  | Ů  | •   | , ,   |                                | 10   | Yes 2 140 3                             | ☐ Probably 4 ☐ Unknown                               |
| Records,   | ~ Q 70   | Completed           |  |  |   |   |                                | 24a. Was                                     | an 24b. We                              | ere autopsy findings available                       |
| Re         | 0 5 0  | omp                 |  |  |   |   |                                | — autor<br>perfo<br>1 ☐ Yes                  | rmed? de                                | or to completion of cause of<br>ath?<br>] Yes 2 2 No |
| Vital      | iclen: Th<br>certificate<br>rector, pag  | BeC                 | 25. Was case referred to medical examiner?   |  |   |   | 26. Place of                   | of Death (Check only of                      |   |  |
| of V       | Physicien:<br>this certific<br>ral director,   | To                  | 1 ☐ Yes 2 ☐ Ho   | Hospital: 1 Inpatie  |   | INT 3 DOA   |                                | sing Home 5 Resid                            | dence 6 Other                           | (Specify)  |
| ion o      | After<br>After<br>fune   |                     | 27. Manner of Death  1 Autural 5 Pending 2 Accident investigation  |  | ry 28b. Time<br>y Year) Injury                  | Wo  | ryat<br>rk?<br>]Yes 2 □ N      |  | now injury occurred                     |  |
| Division   | ei or Attending F<br>s after death.<br>si Director: After<br>ed in by the funeri   | Certification;      | 3 ☐ Suicide 6 ☐ Could not be determined  | e 28e. Place of Injubuilding, etc                                      | ury - At home, farm, s<br>c. <i>(Specify)</i>   | treet, factory, office  |                                | 28f. Location (S<br>City or Tou              |   | or Rural Route Number,                               |
|            | To the Hospitei or Attenc<br>within 24 hours after death<br>To the Funerel Director:<br>completely filled in by the  | edical              | 29a. Certifier (Check only one)  | nysician: To the best of<br>miner: On the basis of<br>and manner sta   | f examination and/or i                          | th occurred at the ti<br>nvestigation, in my o                  | me, date and<br>opinion, death | place, and due to the occurred at the time,  | cause(s) and manr<br>date and place, an | ner as stated.<br>d due to the cause(s)              |
|            |  | Me                  | 29b. Signature and title of certifier  |  |   | 29c. Licens   |                                |  | 29d. Date signed (                      |  |
|            | 15   |                     | MAS 8 for  | ~ MD   |   | De  | 1700°                          | 1  | Decem                                   | ber 11, 2005   |
|            |  |                     | 30. Name and address of person who   | completed cause of d   | leath (Item 23a) (Type                          | Choice  | Lane                           | Balti  | more.                                   | her 11, 2005<br>MD 21228                             |
| 10.        | Sta<br>Regist  |                     | 31. Date filed (Month) Day, Year) DEC 1 2 2  | Registra   | ar's Signature                                  | entil .   |                                |  | ,                                       |  |

DHMH 17 Rev 1/2001

Registrar

DEC 1 3 2005

|                            |   |                     | 1 - State of Ragistrar  |   | artment of Health ar<br>rtificate of Death   |  | ene<br>0 0 5                                  | 41951   |
|----------------------------|---|---------------------|---|---|--|--|---|---|
|                            | Physic  | ian                 | Decedent's Name (First, Middle, Last)   |   |  | 2. Date of Death<br>Month                                | Day Yeer                                      | 3. Time of Death                                    |
|                            | /Med  | cal                 | William Howard Hoover  4a. Facility Name (If not institution, give street and num   |   |  | December   | r 7, 2005                                     | 5:35 PM   |
|                            | Exami<br>   |                     | 227 Providence Road   |   | 4b. City, Town, or Location of [ Annapolis   |  | 4c. County of Dear                            |   |
|                            | Funeral<br>Director   |                     | 5. Social Security Number 6. Sex 1   Usual Residence of Decedent  | 7. Age (In yrs. last birthday) 82 Yrs.  | If Under 1 Year If Under 24  Months Days Hours   | Min. (Month, Day, Y                                      | rear) Co                                      | hplace (State or Foreign<br>buntry)<br>Shington, DC |
|                            | yland<br>sow  |                     | 10a. State 10b. County  | 10c. City, Town or Lo                   | cation   |  |   | 10d. Inside City Limits                             |
|                            | e Mar<br>liffed   | ctor                | Maryland Anne Arundel   |   | Annapol:   | is   |   | 1 ☐ Yes 2 🙀 No                                      |
|                            | with th   | Dire                | 10e. Street and Number  |   | 10f. Zip Code  | 109  | g. Citizen of What Co                         | untry?  |
|                            | eath v  | era                 | 227 Providence Road   |   | 21409  |  | U.S.A.  |   |
| 38                         | be filed within 72 hours after death with the Maryland ntal Hyglene.  Individual than "natural", or Iteme 23a or 28e-f show event, the Medical Exercitive must be notified at   | by Funeral Director | Armed For   | 2 ∐ No                                  | Was Decedent of Hispanic Origin<br>f Yes, specify Cuban, Mexican, P<br>1 ☐ Yes 2 ☑ No Specify: | ? (Specify Yes or No-<br>uerto Rican, etc.)              | 14. Race - Ame<br>Black, White<br>Specify: Wh | e, etc.   |
| 21215-0036                 | 72 hou  | ted                 | 15. Decedent's Education  | 16a. Deced                              | dent's Usual Occupation  | 16   | 6b. Kind of Business/                         | Industry  |
| 121                        | Athin 7   | Completed           | (Specify only highest grade completed) Elementary/Secondary (0-12)  College (1-   | 4or 5+) /ife. L                         | kind of work done during most of<br>DO NOT use retired)  | working  |   |   |
| 12                         | iled w<br>Tygier<br>ther ti   |                     | 17. Father's Name (First, Middle, Last)   |   | Naval Officer  |  | U.S. Nav                                      | У   |
| Maryland                   | e de la la la la la la la la la la la la la   | o Be                | John Howard Hoover  |   |  | Name (First, Middle, Ma.<br>Len Smith                    | iden Sumame)                                  |   |
| aryl                       | s 1 and 2 should if Health and Mentlem 27 is marke other traumatic  | ြင                  | 19a. Informant's Name/Relationship (Type, Print)  | 19b. Mailin                             | g Address (Street and Number o   |  | lity or Town State 7                          | in Code)  |
|                            | and 2<br>ealth a<br>n 27 is   |                     | Carolyn Hoover/wife   |   | roviđence Road   |  |   |   |
| Baltimore,                 | 0 0   |                     | 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from S  | 20b. Place of Dispos                    | sition (Name of natory or other place)   |  | c. Location · City or                         |   |
| Ē                          | Pages<br>tment of I<br>tant: If It  |                     | ' 4 □ Donation 5 □ Other (Specify)  | Baltimor                                | e Crematory 12   | 2/9/2005 B   | altimore,                                     | Maryland  |
| Bal                        | permit. Pag<br>Department<br>important: I<br>any injury o   |                     | 21. Signature of Funeral Solvice Licensee   | lle 14                                  | Name and Address of Facility  7 Duke of Glouc  | John M. Tay<br>ester St.,                                | lor Funera<br>Annapolis                       | al Home   |
|                            |   |                     | 23a. Part1. Enter the disease, or complications that ca<br>shock, or heart failure. List only one cause on ea   | used the death. Do not ente<br>ch line. | er the mode of dying, such as car  | diac or respiratory arrest,                              |   | Approximate<br>Interval Between                     |
|                            | Physician /<br>/Medical   |                     | Immediate Cause (Final disease or condition resulting in death)   | lest                                    | cemiu .  |  |   | Onset and Death                                     |
|                            | Examiner  |                     | Due to (o   | r as a consequence of):                 |  |  |   | NONA  |
|                            |   | Jer                 | Sequentially list conditions, it arms loading to immediate to the sequence of | r as a consequence of):                 |  |  |   |   |
|                            | ocuted<br>nd<br>transit   | Examin              | cause. Enter Underlying Cause (Disease or injury that initiated events  |   |  |  |   |   |
| 60,                        | icate be executed<br>physician and<br>s the burial-transit  | E                   | resulting in death) Last Due to (o  | r as a consequence of):                 |  |  |   |   |
| 68760,                     |   | edical              | d   |   |  |  |   |   |
| . Box                      | death cert<br>e attending<br>d for use a  | Physician/Me        | in the past 12 months?  1   | nt at time of death 5 🗌                 | Ectopic pregnancy Other (specify)  |  | 23d. Date of deliv                            | rery<br>Day Year                                    |
| <u>о</u> .                 | at the<br>f by th<br>stache   | Phys                | 9 □ Unknown 9□ Unknow   |   |  |  |   |   |
|                            | The law requires that the ate has been signed by the page 2 should be detache   | þ                   | Part II. Other significant conditions contributing to dea   |   |  | 23e. Did tobaco  | co use contribute to to 2 No 3 □ Pro          | the cause of death?                                 |
| Division of Vital Records, | The law r<br>ate has be<br>page 2 sh  | Completed           | V   |   |  | 24a. Was an autopsy performed                            | prior to co                                   | opsy findings available impletion of cause of       |
| /ita                       | ician:<br>sertific<br>actor,  | Be                  | 25. Was case referred to medical examiner?  |   | 26. Place of D   | Death (Check only one)                                   | 10 103  | <i>ŞE</i> 1110                                      |
| o                          | Physic<br>this cral din   | ۲.                  | 1 ☐ Yes 2 ☑ No ☐ Hospital: 1 ☐ Inp<br>27. Manner of Death 28a. Date of  |   |  | g Home 5 Aesidence                                       |   | (y)   |
| OU                         | ding<br>th.<br>After<br>tuner   | tlon                | 1 □Natural 5 □ Pending (Month,  | Injury 28b. Time of Injury              | 28c. Injury at<br>Work?<br>M 1 ☐ Yes 2 ☐ No  | 28d. Describe how in                                     | njury occurred                                |   |
| N S                        | Atten<br>ir dea<br>ector.<br>by the   | Certification;      | 3 Suicide 6 Could not be determined 28e. Place of   | Injury - At home, farm, stree           |  | 28f. Location (Street                                    | t and Number or Rus                           | al Route Number                                     |
|                            | tel or<br>safte<br>al Dir   | Cert                | 4 Homicide determined building  | , etc. (Specify)                        |  | City or Town, St   | ta te)  | ar route rumber,                                    |
|                            | To the Hospitel or Attending Physicien: The within 24 hours after death.  To the Funeral Director: After this certificate he completely filled in by the tuneral director, page | edical              | 29a. Certifier 1 Certifying Physician: To the b 2 Medical Examiner: On the bas and manne  | is of examination and/or inve           | occurred at the time, date and pla<br>estigation, in my opinion, death oc                      | ace, and due to the cause<br>ocurred at the time, date a | e(s) and manner as s<br>and place, and due to | tated.<br>the cause(s)                              |
|                            | To t  | Σ                   | 29b. Signature and title of certifier   | 10                                      | 29c. License number  |  | Date signed (Month,                           |   |
| )                          |   |                     |   | -//                                     | 1005/3   | U/ Vec   | ember 8                                       | 2005  |
|                            |   | -                   | 30. Name and address of person who completed cause  | of death (Item 23a) (Type, P            | DOOS/3   | (d) #2n A  | 12000115                                      | 100 2/16  |
|                            | Sta   | e                   | 31. Date filed (Month, Day, Year) 32. 199   | istrar's Signature                      | 0197101-00   | 0 700 /  | vingo is                                      | mo city   |
|                            | Registra  | ar                  | DEC 0 9 2005  | eve & do                                | anti   |  |   |   |

| Privation   Priv   |              |   |       | 1 - For<br>State<br>Registrer                              | State of Maryl                          |                                       | artment<br>rtificate |           |                     | ind Mei               |                                 | 2005<br>.No.             | 1952                                |
|--|--------------|---|-------|--|---|---------------------------------------|----------------------|-----------|---------------------|-----------------------|---------------------------------|--------------------------|-------------------------------------|
| ## February Databases   Security of Data   Security |              | Physic  | ian   | 1. Decedent's Name (First, Middle, Last)  Edgar Earl Jones |   |                                       |                      |           |                     | 2.                    | Date of Death<br>Month          | Day Year                 | 3. Time of Death                    |
| Power of Directors   See a Season Service Management   See   See a Season Service Management   See   See a Season Service Management   See   See a Season Service Management   Season Service Management   Season Service Management   Season Service Management   Season Service Management   Season Service Management   Season Service Management   Season Service Management   Season Service Management   Season Season Service Management   Season Season Service Management   Season Seas   | 1            |   |       |  | street and number)                      |                                       | 4b. City, T          | own, or l | Location of         |                       | recember                        |                          |                                     |
| Social Science (Authority Property   10   10   10   10   10   10   10   1  |              |   |       |  | Living at                               | Hag.                                  |                      |           |                     |                       |                                 |                          |                                     |
| County   C   |              |   |       | 177  |   | **                                    |                      |           |                     | Min.                  | Date of Birth<br>(Month, Day, Y | 9. Birth                 | place (State or Foreign<br>intry)   |
| Section   Part   |              |   |       | 214-09-0195  | 90                                      | 115.                                  |                      |           |                     | No                    | ov. 14,                         | 1915   Ma                | ryland                              |
| Section   Part   |              | how   |       | 10a. State 10b. County                                     | 10c.                                    | City, Town or Lo                      | cation               |           |                     |                       |                                 |                          | 10d. Inside City Limits             |
| Section   Part   |              | Ba-1 s  | ecto  |  | ton                                     | Hagerst                               |                      |           |                     |                       |                                 |                          | 1X Yes 2 □ No                       |
| Section   Part   |              | a or 2  | Dir   |  | Ct Poom                                 | 120                                   |                      |           | ^                   |                       | 10g                             |                          | intry?                              |
| Section   Part   |              | death<br>ms 23  | era   |  | 12. Was Decedent Ever i                 |                                       |                      |           |                     | in? (Specify          | Yes or No-                      |                          | can Indian.                         |
| Section   Part   | 9            | or ite  | Fur   |  | Armed Forces?<br>1☆Yes 2☐No             |                                       |                      |           |                     | Puèrto Ric            | an, etc.)                       | Black, White             | etc.                                |
| Section   Part   | 003          | hours<br>ural',   | d by  |  | Year or Dates:                          |                                       |                      |           |                     |                       |                                 |                          |                                     |
| The companies   The companie   | 15-          | n "nat  | olete | (Specify only highest grade                                | completed)                              | (Give                                 | kind of work         | done du   | ion<br>iring most o | of working            |                                 | _                        | ndustry                             |
| 20. Hard of Disposition   Di   | 212          | d with<br>giene.  | mo    |  |   |                                       |                      |           | y out               |                       |                                 |                          | 16                                  |
| 20. Hard of Disposition   Di   | pu           | be file<br>tal Hy<br>d othe   | Be    |  |   |                                       |                      |           |                     |                       | irst, Middle, Ma                | iden Sumame)             | -8                                  |
| 20. Hard of Disposition   Di   | ryla         | Men's | 10    |  | - / - · · · · · · · · · · · · · · · · · |                                       |                      |           |                     | -                     |                                 |                          |                                     |
| 20. Hard of Disposition   Di   | Ma           |   | 8 1   | , , ,,   |   |                                       |                      |           |                     |                       |                                 |                          |                                     |
| 22. Name and address of Facility  12. Spranger of Gooding (Speechy)  23. Name and a consequence of July 1975 of Gooding in the case of July 2975 of Gooding in the Case of July 2975 of Gooding in the Case of Gooding in the Case of July 2975 of Gooding in the Case of | re,          | f Heal<br>item item   |       | 20a. Method of Disposition                                 | 20                                      |                                       |                      |           |                     |                       |                                 |                          |                                     |
| 22. Name and Address of Facility MINNICH FUNERAL HOME  41.5 E. WILLSon Bl.Vd., Hagerstown, Maryland 21740  Priviled in Minimum College (College College  m o          | Page<br>nent o<br>ant; If<br>ary or   |       |  |   |                                       |                      |           | 1                   | 12/17                 | /05 н                           | agerstown                | Marvland                            |
| 23a. Part I. Enter the disease, or confolications that agreed the dath. On or enterly the node of dying, such as cardiac or respiratory arrest.  Approximate shock, or hear failure. List only one case on a part of the shock or hear failure. List only one case on a part of the shock or hear failure. List only one case on a part of the shock or hear failure. List only one case on a part of the shock or hear failure. List only one case on a part of the shock or hear failure. List only one case on a part of the shock or hear failure. List only one case on a part of the shock or hear failure. List only one case on a part of the shock or hear failure. List only one case on a part of the shock or hear failure. List only one case on a part of the shock or hear failure. List only one case on a part of the shock or hear failure. List only one case on a part of the shock or hear failure. List only one case on a part of the shock or hear failure. List only one case on the shock or hear failure. List only one case on the shock or hear failure. List only one case on the shock or hear failure. List only one case on the shock or hear failure. List only one case on the shock or hear failure. List only one case or hea | Salti        | epartn<br>epartn<br>nporte<br>ny inju   | İ     | 21. Signature of Funeral Service License                   | 9                                       | 1 22                                  | . Name and           | Address   |                     |                       |                                 |                          | , <u>, </u>                         |
| Ptysician Micelical Examiner    Part   College   Part   C | _            | 205 20  |       | SCOU!  | III Junas                               |                                       |                      |           |                     |                       |                                 |                          | and 21740                           |
| Due to (or as a consequence of):    Sequentially list conditions   Sequentially list conditio |              |   |       | Immediate Cause (Final disease or condition                | e cause on sections.                    |                                       | ( )                  |           |                     | ardiac or re          | spiratory arrest                |                          | Interval Between<br>Onset and Death |
| The initiation deviate a consequence of its a ministrate deviate in past 12 months?    The past 12 months?   23c. It yes, outcome of prepriarcy   23c. It yes,  | Н            |   |       |  | Due to (or as a con                     | sequente (f):                         |                      |           |                     |                       |                                 |                          |                                     |
| The initiation deviate a consequence of its a ministrate deviate in past 12 months?    The past 12 months?   23c. It yes, outcome of prepriarcy   23c. It yes,  |              |   | ner   | Sequentially list conditions, if any, leading to immediate |   | sequence of):                         |                      |           |                     |                       |                                 |                          |                                     |
| State  |              | ecuter<br>and<br>-transi  | cami  | that initiated events                                      |   |                                       |                      |           |                     |                       |                                 |                          |                                     |
| FFEMALE:   23c. If yes, outcome of pregnancy   1   Live birth   2   Fetal death   3   Ectopic pregnancy   23d. Date of delivery   Month   Day   Year   | 60,          | be ex<br>ician a<br>burial  |       | rosaning in southly East                                   | Due to (or as a con:                    | sequence of):                         |                      |           |                     |                       |                                 |                          |                                     |
| The state of the s |              | ificate<br>g phys<br>as the   | edic  | d  |   |                                       |                      |           | -                   |                       |                                 |                          |                                     |
| The state of the s | Sox          | th cert<br>tendin<br>r use  | an/M  | 23b. Was decedent pregnant 23                              |   |                                       | Ectonic ored         | nnancv    |                     |                       |                                 | 23d. Date of delive      | эгу                                 |
| The state of the s |              | 0 0   | sici  | 1 ☐ Yes 2 ☐ No   | 4☐Pregnant at time of                   |                                       |                      |           |                     |                       |                                 | Month                    | Day Year                            |
| The state of the s | Д.           | that the  |       | Part II. Other significant conditions conf                 | tributing to death but not              | resulting in the un                   | derlying cau         | ıse given | in Part I.          |                       | 23e. Did tobac                  | co use contribute to the | ne cause of death?                  |
| 25. Was case referred/o medical examiner?  26. Place of Death (Check only one)  27. Man if of Death  1   Natural   5   Pending investigation    28a. Date of Injury    28b. Time of Injury    28b. Time of Injury    28c. Injury at Work?  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Location (Street and Number or Rural Route Number, City or Town, State)  29a. Certifier (Check only one)  29a. Certifier (Check only one)  29a. Certifier (Check only one)  29b. Signature and title of certifier  29c. License number  29c. License number  29d. Date signed (Month, Day, Year)   | rds          | quires<br>an sign<br>uld be   | ed ba |  |   |                                       |                      |           |                     | _                     | 1 🗆 Yes                         | 2 □ No 3 □ Prob          | pably 4 Unknown                     |
| 25. Was case referred/o medical examiner?  26. Place of Death (Check only one)  27. Man if of Death  1   Natural   5   Pending investigation    28a. Date of Injury    28b. Time of Injury    28b. Time of Injury    28c. Injury at Work?  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Location (Street and Number or Rural Route Number, City or Town, State)  29a. Certifier (Check only one)  29a. Certifier (Check only one)  29a. Certifier (Check only one)  29b. Signature and title of certifier  29c. License number  29c. License number  29d. Date signed (Month, Day, Year)   | eco          | law re<br>as bee<br>2 sho   | plet  |  |   |                                       |                      |           |                     |                       |                                 | 24b. Were auto           | psy findings available              |
| 1   1   1   1   2   2   3   3   3   3   3   3   3   3  | œ<br>=       | The   | Com   |  |   |                                       |                      |           |                     |                       | performed                       | death?                   |                                     |
| 1   1   1   1   2   2   3   3   3   3   3   3   3   3  | Vita         | ician<br>certifii<br>rector   | 00    | examiner?  | osnital:                                |                                       |                      | -         |                     |                       |                                 |                          |                                     |
| 30. Name and address of person the completed cause of health (Hem 23a) (Type, Print)  Jeff Hurwitz 11110 Mydical Campus Rol Ste 130 Hagerstown Md 21740  State 31. Date filed (Month Par Year) 12 0005 32. Registrar's Signature   | o            | Physic this stal dii  |       | 27. Manual of Death  | 1 ∐ Inpatient 2<br>28a. Date of Injury  | 28b. Time of                          |                      |           | 4 Nurs              |                       |                                 |                          | y)                                  |
| 30. Name and address of person the completed cause of health (Hem 23a) (Type, Print)  Jeff Hurwitz 11110 Mydical Campus Rol Ste 130 Hagerstown Md 21740  State 31. Date filed (Month Par Year) 12 0005 32. Registrar's Signature   | ion          | nding<br>ath.<br>r: Afte<br>e fune  | atior |  | (Month, Day Year                        |                                       |                      |           |                     |                       |                                 | injury cocurrou          |                                     |
| 30. Name and address of person the completed cause of health (Hem 23a) (Type, Print)  Jeff Hurwitz 11110 Mydical Campus Rol Ste 130 Hagerstown Md 21740  State 31. Date filed (Month Par Year) 12 0005 32. Registrar's Signature   | <u>ivi</u> s | r Atte<br>ter dea<br>irecto<br>by th  | tific | determined   | 28e. Place of Injury - A                | t home, farm, stre                    | et, factory,         | office    |                     | 28f.                  | Location (Street                | t and Number or Rura     | I Route Number,                     |
| 30. Name and address of person the completed cause of health (Hem 23a) (Type, Print)  Jeff Hurwitz 11110 Mydical Campus Rol Ste 130 Hagerstown Md 21740  State 31. Date filed (Month Par Year) 12 0005 32. Registrar's Signature   |              | pital o   |       |  |   |                                       |                      |           |                     | 1                     |                                 |                          |                                     |
| 30. Name and address of person the completed cause of health (Hem 23a) (Type, Print)  Jeff Hurwitz 11110 Mydical Campus Rol Ste 130 Hagerstown Md 21740  State 31. Date filed (Month Par Year) 12 0005 32. Registrar's Signature   |              | the Hos<br>hin 24 ho<br>the Fun<br>npletely f   |       | one) Medical Examin  | er: On the basis of exam                | nowledge, death<br>ination and/or inv | estigation, ir       | n my opin | ion, death          | place, and occurred a | t the time, date                | and place, and due to    | the cause(s)                        |
| 30. Nam and address of person who completed cause of death (Item 23a) (Type, Print)  Teff Hurnitz 11110 knydical Campus Rol Ste 130 Hagerstown Md 21740  State  31. Date filed (Month Par Year) 1000 32. Refistrar's Signature   | •            | Wit<br>To   | -     | 290. Signature and after of certifier                      | A                                       | ph sun                                | $\sim$               |           |                     | 783                   |                                 | Date signed (Month,      | Day, Year)                          |
| State 31. Date filed (Month Pay Year) 22. Registrar's Signature  | 5H:          | 3+1   |       | TO ALL   | million Id.                             |                                       | Print)               |           |                     |                       |                                 | stown ma                 | 21740                               |
|  |              |   |       | 31. Date filed (Month Day Year) 5 20                       |   | gnature                               | 1                    |           |                     |                       | <i>U</i>                        | -                        |                                     |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State F. H., TCHD/12.14.05, sbb Amended 5, per Reguno 1. Decedent's Name (First, Middle, Last) 2. Date of Death DECEMBER 12 **Physician** 2005 10:51PM™ MARY BISHOP KEITH JUKES /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner TALBOT EASTON WILLIAM HILL MANOR If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 910 7. Age (In yrs. last birthday) 5. Sopial Sepurity Humber 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🔻 MARYLAND 95 Yrs <del>212-13-5271</del> Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-1 show other traumatic event, the Medical Examinar must be notified at 1 Yes 2 ☐ No Director **EASTON** TALBOT 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21601 USA 501 DUTCHMANS LANE Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status within 72 hours after 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🗶 No Specify: δ Specify: WHITE 3 XWidowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. ant: If Item 27 Is marked other than " Elementary/Secondary (0-12) OWN HOME HOMEMAKER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be JOHN WILLIAM KEITH ELVA BISHOP 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MARY J. HOWARD/DAUGHTER 3908 MORMAN LANE, ADDISON, TX 75001 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages Department of the Important: If ite 1 ☐ Burial 2 XCremation 3 ☐ Removal from State ō CHESAPEAKE CREMATION CTR 12/13/2005 STEVENSVILLE, MD <sup>¹</sup> 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL
200 S. HARRISON ST EASTON, MD 21601 HOME PA Joseph .- M. Uster C. F. S.P. Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause a each line. Immediate Cause (Final disease or condition **Physician** recemonia /Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examiner the death certificate be executed the attending physician and ned for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy Day Year 5 Other (specify) P.O. I detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 90 2 **2**00 3 Probably 4 Unknown 1 Yes Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 has autopsy certificate 2 🗌 No 2**2**No 1 Yes Division of Vital Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tyes 2 297 No 2 ER/Outpatient 3□ DOA this 27. Manner of Sath funeral 28b. Time of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Certification; After 5 Pending investigation death. M 1 ☐ Yes 2 ☐ No in by the 2 Accident within 24 hours after deatl To the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital completely filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 35284 who completed cause of death (Item 23a) (Type, Print)

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)
DEC 1 3 2005

Auon

mo

ANDREA



Jashington St Eastman 21601

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg: No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Beverly Jones December 2005 1245 A<sub>M</sub> /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** 517 Fieldstone Road Silver Spring Montgomery If Under 1 Year If Under 24 Hrs. Date of Birth (Month, Day, Year) 8/22/1949 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🕌 F Days Hours 073-48-7901 56 Jamaica Director Usual Residence of Decedent permit. Pagas 1 and 2 should be filed within 72 hours atter death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "netural", or Items 23e or 28e-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits important: If item 27 is marked other than "natural", or items 23s or 28e-f show any injury or other traumatic event, the Madical Examiner must be notified at once. 1 Yes 2 XNo Director Marvland Montgomery Silver Spring 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 517 Fieldstone Road 20905 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 Never Married 2 Married ☐Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. þ If Yes, Give Year or Dates: Specify: 3 ☐ Widowed 4 ☐ Divorced Black Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Banker Mortgage Banking 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Hines Ivett Pendrey Oswa1d 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Jesse Jones - Husband 517 Fieldstone Rd; Silver Spring MD 20905 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 2/10/2005 Parklawn Memorial Gardens ' 4 ☐ Donation 5 ☐ Other (Specify) Rockville, MD 22. Name and Address of Facility Hines-Rinaldi Funeral Home 21. Signature of Funeral Service License Welin letrer 11800 New Hampshire Ave; Silver Spring MD 20904 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** Metastatic Breast Cancer 7 Years resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner The law requires that the death certificate be executed the attending physician and the tor use as the burial-tranthat initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records. P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? Live birth 2 Fetal death 3 □Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) ☐ Yes 2 XNo datachad 9 Unknown 9 Unknown ģ signad Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by ba 1 Tyes 2 🗔 No 3 Probably 4 Unknown Completed baan s 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has paga 2 autopsy cartificata 2 No 1 Yes To the Hospital or Attanding Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one. 2 No Hospital: Other: 4 \(\) Nursing Home \(5\)\(\) Residence \(6\)\(\)Other (Specify) 1 🗀 Yes B 2 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Aftar t Certification; Natural 5 Pending investigation М 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after daat e Funeral Diractor: 6 Could not be 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 15. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical (Check only one) the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2 D37236 December 7, 2005 son who completed cause of death (Item 23a) (Type, Print) 30. Name and address of pe 6410 Rockledge Dr. Ste. 506; Bethesda MD 20817 Carolyn B, M.D. Hendricks Registrar's Signature 31. Date filed (Month, Day, Year) State 1 2 2005 DEC Registrar

|             |   |                               | 1 - For<br>State<br>Registrar  | State of Maryla   |  |   | nt of He<br>te of D                                |                                       | nd Me                     |  | ene                    | 05                                       | 41955   |
|-------------|---|-------------------------------|--|---|--|---|--|---------------------------------------|---------------------------|--|------------------------|--|---|
|             | Physic<br>/Medi   |                               | 1. Decedent's Name (First, Middle, La<br>Frances Louise  | st)<br>Johnson  |  |   |  |                                       |                           | Date of Death<br>Month<br>December             |                        | , 2005                                   | 3. Time of Death 9:40P. M                           |
| X           | Exami   |                               | <sup>4a.</sup> Facility Name (If not institution, giv<br>Holy Cross Hospi  | e street and number)<br>tal   |  | Sil   | Town, or I   | Spring                                | g                         |  |                        | ounty of Death<br>Montgo                 |   |
| e e         | Funeral<br>Director   |                               | 330 10 3323  |   | (last birthday)                            | If Unde<br>Months                             | Days   | Hours                                 | Min. 8                    | Date of Birth<br>(Mooth, Bay,<br>July3,1       | 915                    | (20)                                     | nplace (State or Foreign<br>untry)<br>Cago, Illinoi |
|             | Maryland<br>P-f ahow  | tor                           | Usual Residence of Decedent  10a. State Maryland Prince  |   | ity, Town or Lo<br>lelphi                  | ocation                                       |  |                                       |                           |  |                        |  | 10d. Inside City Limits 1 ☐ Yes 2 XNo               |
|             | h with the<br>23a or 28   | ai Dire                       | 10e. Street and Number<br>2603 Hughes Road   |   |  | 10f. Zij                                      | 20783  | 3                                     |                           | 10   | _                      | n of What Coo                            | •   |
| 980         | permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hygiene. Importent: if item 27 is marked other than "natural", or items 23a or 28a-f show say injury or other traumatic event. The Medical Examinat must be notified at once. | Completed by Funeral Director | 11. Marital Status  1 Never Married 2 Married  Widowed 4 Divorced  | 12. Was Decedent Ever in Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:             |  |   | dent of His<br>ecify Cuban<br>2 No                 | panic Origi<br>, Mexican,<br>Specify: | in? (Specif<br>Puerto Ric | fy Yes or No-<br>can, etc.)                    |                        | . Race - Amer<br>Black, White<br>pecify: |   |
| 21215-0036  | od within 72 hu<br>giene.<br>er then "netu<br>. Itse Madical  | Completed                     | 15. Decedent's E<br>(Specify only highest gra-   | ducation<br>ade completed)<br>College (1-4or 5+)  | (Give                                      | dent's Usu<br>kind of wo<br>DO NOT L<br>OMEMA | ial Occupat<br>ork done du<br>ise retired)<br>iker | ion<br><i>iring</i> most              | of working                | 1  |                        | of Business/l                            |   |
| Maryland    | ould be file<br>Mental Hy<br>arked oth  | To Be (                       | 17. Father's Name (First, Middle, Last, Henry L. Jenson  |   |  |   |  |                                       | 's Name (#                | J. Pip   |                        | ımame)                                   |   |
| , Mar       | end 2 sho<br>Balth and<br>n 27 is m   |                               | 19a. Informant's Name/Relationship ( Donna L. Jarvis   | -daughter   | 2603                                       | Hugh  | es Ro  | ad Ad                                 | delph                     | i, Mary  | land                   | 20783                                    |   |
| Baltimore,  | Pages 1<br>nent of H<br>ent: if ite   |                               | 20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3 ☐  4 ☐ Donation 5 ☐ Other (Specif   |   | Place of Dispo<br>cometery, crei<br>rshfie | ld Ce   | meter  | y  12                                 | Dat<br>2/13/:             | 2005   | Mars                   |  | , Missouri  |
| Balt        | permit. Depertr import. any inj.  |                               | 21. Signature of Funeral Service Licer   | Tromas.   | D6   | 3 <b>naid</b><br>400 P                        | owder  | orgwa<br>Mill                         | ardt 1<br>L Road          | Funeral<br>d Belts                             | Hom<br>vill            | e, PA<br>e, Mar                          | yland 20705   |
|             | Physician   |                               | 23a. Part1. Enter the disease, or com<br>shock, or heart failure. List only<br>Immediate Cause (Final<br>disease or condition  | plications that caused the dea<br>one cause on each line.<br>Pneumonia                    | ith. Do not ent                            |   |  |                                       |                           |  |                        |  | Approximate<br>Interval Between<br>Onset and Death  |
| 1 to        | /Medical<br>Examiner  |                               | resulting in death)  | Oue to (or as a conse<br>Dementia   | quence of):                                |   |  |                                       |                           |  |                        |  |   |
|             | cuted and nd  | Examiner                      | Sequentially list conditions, lary leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events   | Due to (or as a consider  | quence of):                                |   |  |                                       |                           | _  |                        |  |   |
| 8760,       | ate be exe<br>nysicien ar<br>he burial-t  | ca                            | resulting in death) Last   | Due to (or as a conse   | quence of):                                |   |  |                                       |                           |  |                        |  |   |
| .O. Box 68  | that the death certificate be executed ted by the ettending physicien and detached for use as the buriat-transit  | Physician/Med                 | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ②No 9 ☐ Unknown   | 23c. If yes, outcome of pregr<br>1 Live birth 2 Fet<br>4 Pregnant at time of<br>9 Unknown | al death 3                                 | Ectopic p                                     |  |                                       |                           |  | 230                    | I. Date of delik<br>Month                | v <b>ery</b><br>Day Year                            |
| ٥           | signed by   | Ď                             | Part II. Dther significant conditions of   | contributing to death but not re  | sulting in the u                           | nderlying                                     | cause giver  | in Part I.                            |                           |  | acco use               |  | the cause of death?                                 |
| Il Records, | The law requires that the rate has been signed by th page 2 should be detache   | Completed                     |  |   |  |   |  |                                       |                           | 24a. Was an<br>autopsy<br>perform<br>1 ☐ Yes 2 |                        | prior to dideath?                        | opsy findings available ompletion of cause of       |
| f Vital     | Physician: Th<br>this certificate<br>ral director, pag  | To Be                         | 25. Was case referred to medical examiner?  1  Yes 2 No  | Hospital: 14 Inpatient 2  | ER/Outpatier                               | nt 3 D  | Othor  |                                       |                           | Check only one                                 |                        | Other (Speci                             | ify)  |
| ion of      | fe fe   |                               | 27. Magner of Death 1 ⚠Natural 5 ☐ Pending 2 ☐ Accident investigation  | 28a. Date of Injury<br>(Month, Day Year)  | 28b. Time of<br>Injury                     |   | 28c. Injury a<br>Work?<br>1 ☐ Ye                   | at<br>es 2 ⊡No                        |                           | d. Describe how                                | v injury o             | ccurred                                  |   |
| Division    | el or Atte<br>s efter de<br>il Directo<br>ed in by th   | Certification;                | 3 Suicide 6 Could not b<br>4 Homicide determined   | 28e. Place of Injury - At I<br>building, etc. (Spec                                       | nome, farm, str<br>ify)                    | eet, factor                                   | y, office  |                                       | 28f                       | Location (Stre<br>City or Town,                |                        | lumber or Rui                            | ral Route Number,                                   |
|             | To the Hospitel or Attendi<br>within 24 hours efter death.<br>To the Funeral Director; A<br>completely filled in by the fu  | edicai (                      | 29a. Certifier (Check only one) 112 Medical Example | nysician: To the best of my kn<br>niner: On the basis of examin<br>and manner stated.     | cw/edge, death<br>ation and/or in          | vestigation                                   | at the time<br>n, in my opin                       | date and<br>nion, death               | clane, and<br>occurred    | due to the cau<br>at the time, da              | ise(s) on<br>e and pla | d manner as a<br>ace, and due t          | stated<br>to the cause(s)                           |
|             |   | Me                            | 29b. Signature and title of certifier  | 0,00  |  | 1   | c. License i<br>DO067.                             |                                       |                           |  |                        | igned (Month)<br>nber 8                  |   |
|             | 10  | M                             | 30. Name and address of person who Maria D'Arbela, M   | completed cause of death (IIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIII                            | m 23a) (Type,<br>Glen R                    | Print)  | Silve  | r Spr                                 | ing,                      | Marylar  | nd 20                  | 0910                                     |   |
| 4           | Sta<br>Registr  |                               |  | 82. Registrar's Sign  |  |   |  |                                       |                           | -  |                        |  |   |

|  |                 | 1        | For<br>State<br>Registrar  |                         | State                           | of Mar                  | yland       | -                            | rtmen<br>tificat         |                          |                                       | and M       | ental Hy                       | gien<br>Reg. No                | UUJ                                | 41956                           |   |
|--|-----------------|----------|--|-------------------------|---------------------------------|-------------------------|-------------|------------------------------|--------------------------|--------------------------|---------------------------------------|-------------|--------------------------------|--------------------------------|------------------------------------|---------------------------------|---|
| Physi  | iciar           |          | I. Decedent's Name (First, M.  | iddle, Last             | )                               |                         |             |                              |                          |                          |                                       |             | 2. Date of De<br>Month         | Da                             |                                    | 3. Time of Death                |   |
| /Med   | dica            |          | Ethel Mae  a. Facility Name (If not instit                                   |                         | shefsk                          |                         |             |                              | Ab City                  | Town or                  | Location o                            |             | Dec. 1                         |                                | 005<br>County of Dea               | 10:40 P <sup>M</sup>            | _ |
| Exam   | nine            |          | 3869 Kahler F  | -                       | 30,660 200 00                   | 1110017                 |             |                              |                          |                          | lains                                 | J Death     |                                |                                | Charle                             |                                 |   |
| Funera   | al              | 5        | 5. Social Security Number  | 6. Se                   | х<br>⊐м <b>Ж</b> ⊐ F            |                         | -           | st birthday)                 | If Under<br>Months       |                          | If Under 2                            | Min         | 8. Date of Bit<br>(Month, Da   | th<br>ay, Year                 | 9. Bi                              | rthplace (State or Foreign      | 1 |
| Directo  | or              | <u> </u> | .64-24-3520<br>Usual Residence of Deceden                                    |                         |                                 | 75                      | 5           | Yrs.                         |                          |                          |                                       |             | Jan. 2                         | 5, 1                           | 930 Pen                            | nsylvania                       |   |
| yland  |                 | -        | 10a. State 10b. Col  |                         | -                               | 1                       | I0c. City,  | Town or Lo                   | cation                   |                          |                                       |             |                                |                                |                                    | 10d. Inside City Limits         | _ |
| e Mar<br>8e-f sl   | , c             | S M      | laryland Chai  | ·les                    |                                 |                         |             | White                        |                          |                          |                                       |             |                                |                                | _                                  | 1 ☐ Yes 24☐ No                  |   |
| with the   | Cinoral Directo | 1        | 10e. Street and Number   | ا د د (                 |                                 |                         |             |                              | 10f. Zip                 | Code                     | 2000                                  | _           |                                | 10g. C                         | tizen of What C                    | Country?                        |   |
| death<br>ms 23   | 010             | <u> </u> | 3869 Kahler F  | load                    | 12. Was Dec                     |                         | er in U.S   | S. 13. V                     | Vas Deced                | lent of Hi               | 2069                                  |             | cify Yes or No<br>Rican, etc.) | <b>)-</b>                      | US<br>14. Race - Am                |                                 | _ |
| after or Ite   |                 |          | 1 Never Married 2  |                         | Armed F<br>1 ☐ Yes<br>If Yes, G | 2 X No                  |             |                              | r Yes, spec<br>I □ Yes : |                          | n, Mexican<br>Specify:                | i, Puerto i | Hican, etc.)                   |                                | Black, Wh  Specify:                | <sub>ite, etc.</sub><br>White   |   |
| hours af   | P. P.           |          | 3 X Widowed 4 □ Divo   | dent's Edu              | Year or I                       | Dates:                  |             | 16a. Deced                   |                          |                          |                                       |             |                                | 16b k                          | (ind of Busines                    |                                 | _ |
| FID:   | Completed       | -        | (Specify only his  | ghest grad              | le completed                    | )<br>(1-4or 5+)         |             | (Give                        | kind of wor<br>DO NOT us | rk done a                | luring most                           | t of workii | ng                             | 100.1                          | Cind of Dusines.                   | arridustry                      |   |
| or the   | 2               |          | 12   |                         | College                         | (1-401 54)              | <u></u>     | Но                           | memal                    | ker                      |                                       |             |                                |                                | Own H                              | ome                             | _ |
| Id be fill ental Hy ked oth  | ď               | ָ<br>ב   | 17. Father's Name (First, Mid  |                         |                                 |                         |             |                              |                          |                          | 18. Mothe                             |             | (First, Middle                 |                                |                                    |                                 |   |
| Ite, INIATY IZITIO ZIZIO-0000  s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other then "neturel", or Items 23a or 28e-f show other treumatic event, the Medical Example in Itimatic Literature. | F               | -  -     | William Phill 19a. Informant's Name/Relat                                    |                         | ype, Print)                     |                         |             | 19b. Mailin                  | g Address                | (Street a                | and Numbe                             |             | ris Sie<br>IRoute Numb         |                                | C<br>or Town, State,               | Zip Code)                       |   |
| VICT 12  |                 |          | Dave Krashefs  | ki -                    | Son                             |                         |             | 4361                         | Piper                    | Lar                      | ne, Ma                                | arbui       | ry, MD                         | 206                            | 58                                 |                                 |   |
| of He  |                 | 2        | 20a. Method of Disposition   | ion 3 □1                | Removal from                    | State                   | Ce          | ace of Dispo<br>metery, cren | sition (Nam              | ne of<br>ther place      | 9)                                    | D           | ate                            | 20c. L                         | ocation - City o                   |                                 |   |
| Datuffilor Dermit. Pages Department of I mportent: If It any injury or o   |                 |          | `4 ☐ Donation 5 ☐ Othe   | r (Specify)             | )                               |                         |             |                              |                          |                          |                                       |             |                                |                                | ltenham                            |                                 |   |
| Datumore, permit. Pages 1 and Department of Heall Importent: If Item 2 any injury or other   | once            |          | 21. Signature of Funeral Ser   | A. B.                   | A RA                            | 00053                   | 3           |                              |                          |                          | s of Facility                         |             |                                |                                | dashing                            | ton Rd.<br>, MD 20604           |   |
| Ž  |                 | +        | 23a. Part1. Enter the diseas shock, or heart failure.                        |                         |                                 |                         |             |                              |                          |                          |                                       |             |                                |                                | Maruuri                            | Approximate<br>Interval Between |   |
| Physicia   | n               |          | Immediate Cause (Final disease or condition                                  | List Only O             | Ν                               |                         | MAI         | n Cr                         | ul?                      | Lv                       | WG                                    | CE          | mer                            | W                              |                                    | Onset and Death                 |   |
| /Medica  |                 |          | resulting in death)  |                         | Due to                          | (or as a                | consequ     |                              |                          |                          |                                       | 1           |                                |                                |                                    | 0                               |   |
|  | ш.              | 5        | Sequentially list conditions, if any, leading to immediate                   |                         | b. Due to                       | (or as a                | consequ     | ence of):                    | _                        |                          |                                       |             |                                |                                |                                    |                                 |   |
| suted<br>d<br>ansit  | Evaminar        |          | cause. Enter Underlying<br>Cause (Disease or injury<br>that initiated events | 1                       | c                               |                         |             |                              |                          |                          |                                       |             |                                |                                |                                    |                                 |   |
| e be exect<br>sicien an<br>burial-tr   | ŭ               | LA       | resulting in death) Last   |                         | Due to                          | (or as a                | consequ     | ence of):                    |                          |                          |                                       |             |                                |                                |                                    |                                 |   |
| a # 2 E  | lecipo          | 2        |  | •                       | d                               |                         |             |                              |                          |                          |                                       |             | <u> </u>                       |                                |                                    |                                 | _ |
| w requires that the death certifies been signed by the attending ph should be detached for use as t  | n/Mg            |          | IF FEMALE:<br>23b. Was decedent pregnan                                      |                         | 23c. If yes, or                 |                         |             |                              |                          |                          |                                       |             |                                |                                | 23d. Date of de                    | alivery                         |   |
| death<br>death<br>ne atte  | M/acicion/M     | 200      | in the past 12 months?   |                         |                                 | birth 2<br>inant at tii |             |                              | Ectopic pr<br>Other (sp  |                          | ··-                                   |             |                                |                                | Month                              | Day Year                        |   |
| at the d by the letach   | Dhy             |          | 9 ☐ Unknown  Part II. Other significant cor                                  | ditions or              |                                 |                         | not recu    | lting in the ur              | nderhing o               | auco give                | on in Part I                          |             | 23e Did                        | obacco                         | use contribute                     | to the cause of death?          |   |
| w requires to been signed should be de-  | 2               | 2        | arti. Galor organicality   |                         | antinouting to                  | douth but               |             | iting in the di              | idonying o               | auso give                | , , , , , , , , , , , , , , , , , , , |             | 135                            |                                |                                    | Probably 4 Unknown              |   |
| w req  | oto             | ובונים   |  |                         |                                 |                         |             |                              |                          |                          |                                       |             | 24a. Was                       |                                | 24b. Were a                        | utopsy findings available       | _ |
| VICAL DEC<br>siclan: The law<br>scertificate has b<br>lirector, page 2 s   | Completed       | 5        |  |                         |                                 |                         |             |                              |                          |                          |                                       |             | auto<br>perfo                  | psy<br>ormed?<br>2 <b>S</b> KN | death?                             |                                 |   |
| ysiclan: The ysiclan: The is certificate hi director, page   | a               | ו        | 25. Was case referred to me examiner?  |                         | IIIikali                        |                         |             |                              |                          |                          |                                       | of Death    | (Check only                    |                                |                                    |                                 | _ |
| 2 £ # B  | F               | -  -     | 1 ☐ Yes 2 No<br>27. Manner of Death  |                         | Hospital: 1 _                   | Inpatient<br>of Injury  |             | R/Outpatien<br>28b. Time of  |                          |                          | 4 🗆 Nu                                | rsing Hor   | ne 5 Resi<br>28d. Describe     |                                | 6 ☐Other (Spa                      | ecify)                          |   |
| Attending ar death. ector: Atter by the fune   | - in            |          | 1 XNatural 5 ☐ Pe  | nding<br>restigation    | (Mo                             | nth, Day                | Year)       | Injury                       | М                        | 8c. Injury<br>Work       | (?<br>/es 2 □ I                       |             |                                |                                | 10                                 |                                 |   |
| or Attending<br>or Attending<br>ifter death.<br>Director: Attel  | ortification.   | 2        |  | ould not be<br>termined | 28e. Plac                       | e of Injun              |             | ne, farm, str                | eet, factory             | , office                 |                                       | 2           | 28f. Location (<br>City or To  |                                |                                    | Rural Route Number,             | _ |
| pltel o  | (               | ۷        | 20a Confice 119/Con  | ificina Dh              | raining T- #                    | - hant of               | and the new | Jadaa daas                   |                          |                          |                                       | d =1000 d   |                                |                                | \ d                                |                                 | _ |
| To the Hospitel or Attending F<br>within 24 hours after death.<br>To the Funerel Director; Atter<br>completely filled in by the funer.   | Coipo           | מונים    | 29a. Certifier 1 Cert<br>(Check only 2 Med<br>one)                           | ical Exam               | iner: On the                    | basis of e              | xaminati    | on and/or in                 | estigation.              | at the tim<br>, in my of | pinion, deal                          | th occurre  | ed at the time,                | date an                        | i) and manner a<br>d place, and du | e to the cause(s)               |   |
| To th<br>To th<br>comp   | 1               |          | 29b. Signature and title of ce   | rtifier                 |                                 | M                       |             | (                            | 290                      | License                  | number                                | 1           | 0 0                            | 29d. Da                        | ate signed (Mor                    | nth, Day, Year)                 |   |
| <  | 4               | -        | 1 Jun  | 1-3                     | No                              | 71                      |             | YW                           | ) 3                      |                          | 20                                    | 66          | 7                              | 1                              | 112                                | 102                             |   |
| MP3  |                 |          | CT REAT  | CV2                     | completed cau                   | NA                      | TIR         | from                         | W                        | <u>n</u> -               | Mf                                    | Fr          | Don                            | N-,                            | MI                                 | (20103)                         | > |
| Regi   | State<br>stra   | -        | 31. Date filed (Month, Day, )  | 1 3                     | 2005                            | Modistrar               | 3 Signat    | ure /                        | Coast                    | و                        |                                       |             |                                |                                |                                    |                                 |   |

| Type or Print in Black | indelible ink.  | Ensure All C  | opies Are   | Legit |
|------------------------|-----------------|---------------|-------------|-------|
| State of Maryland / Do | epartment of He | ealth and Men | ital Hygien | е     |

|  | 1 - State<br>Registrar   |  | C  | ertificate of  | Death  |  | Reg. Na.  | E L   | 957  |
|--|--|--|--|--|--|--|---|---|--|
| cian<br>dical  | Decedent's Name (First, Middle, NANCY  | KESTLE   |  | th City Tayra  | al anation of Do   | 2. Date of De Month <b>DEC</b> • 9   | Day   | Year  | 3. Time of Death 9:20 A  |
| iner   | 4a. Facility Name (If not institution, 2209 PINEFIELD  | COURT  | er)<br>Age (In yrs. last birthda   | 4b. City, Town, o  WALDO  If Under 1 Year  |  |  | СНА   | RLES  | /Chata as Cast   |
| al<br>or   | 5. Social Security Number 170-03-7149 Usual Residence of Decedent  | 6. Sex 7. /<br>1 □ M 2 □ <b>X</b> F  | 95 Yrs.  | Months Days  |  | in. MAY 12   | 1910  | MARYL   | AND  |
| tor  | 10a. State 10b. County  MARYLAND CHA   | RLES   | 10c. City, Town or   |  | ALDORF   |  |   | 10  | d. Inside City Lin   |
| Director   | 10e. Street and Number   |  |  | 10f. Zip Code  | 0.601  |  | 10g. Citizen of V   |   |  |
| d by Funeral   | 11. Marital Status  1 Never Married 2 Marrie 3 XWidowed 4 Divorced   | 12. Was Deceder<br>Armed Force   | <b>X</b> No  | 3. Was Decedent of H If Yes, specify Cuba 1  Yes 2 X No  | dispanic Origin?<br>an, Mexican, Pu<br>Specify:                  | (Specify Yes or No<br>erto Rican, etc.)  |   |   | ın Indian,   |
| Completed  | 15. Decedent<br>(Specify only highest<br>Elementary/Secondary (0-12)   | 's Education<br>t grade completed)<br>College (1-40  | (G.  | cedent's Usual Occup<br>ive kind of work done<br>e. DO NOT use retired<br>SECRET   | during most of v<br>d)   | vorking  | 16b. Kind of B  |   | ustry  |
| To Be Co   | 17. Father's Name (First, Middle, L  JOSEPH AMBROSE  |  |  |  | 18. Mother's N   | lame (First, Middle ARET ADE)  | , Maiden Surnarr  | 10)   |  |
|  | 19a. Informant's Name/Relationsh   | 1 ( ) , ,  |  | ailing Address (Street   |  |  | -   |   |  |
|  | RICHARD E. BAMB 20a. Method of Disposition   |  | 20b. Place of Dis  | sposition (Name of crematory or other place  |  | Date<br>EMBER  | 20c. Location -   |   |  |
|  | 1  Burial 2  □ Cremation  '4 □ Donation 5 □ Other (Sp  |  | te   | HEART CEM.   |  | , 2005   | LA PLAT   | A, MA   | RYLAND   |
| ouce.  | 21. Signature of Funeral Service L   | Swham ]  | M00053   | 22. Name and Addre   |  | E, P.O.B   | X 156,  | WALDO   | 20604<br>RF, MD  |
|  | 23a. Part1. Enter the disease, or o  | complications that cause   |  |  |  |  |   |   |  |
| 1  | Immediate Cause (Final disease or condition  | only one cause on each   | ATURNA   | enter the mode of dyir   | ng, such as card   |  | pilww   |   |  |
| al<br>er   | Immediate Cause (Final disease or condition resulting in death)  | aDue to (or a  | ATURNA as a consequence of):   | CANS<br>I CAMP   | ng, such as card   | CAMPS O  |   |   | Interval Betweer   |
| il<br>r  | Immediate Cause (Final disease or condition  | a  | ATURNE   | CANS<br>I CAMP   | ng, such as card   | CAMPS O  | pilwer  |   | Interval Betweer   |
| dlcai Examiner   | Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events   | a  | as a consequence of):  Left  | CANS<br>I CAMP   | ing, such as card  | CAMPS O  | pilwer  |   | Approximate Interval Between Onset and Death  mine t  Z  Say   |
| edicai Examiner  | Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events   | a.  Due to (or a Due to (or a d.)  23c. If yes, outcon   | as a consequence of):  Left as a consequence of):  Left as a consequence of):  Left as a consequence of):  Left as a consequence of):  Left as a consequence of):  Left as a consequence of):  | CANS<br>I CAMP   | ins/   | CAMPS O  | piloson<br>Thans h  | te of deliver   | Interval Between Onset and Death   |
| by Physician/Medical Examiner                                | Immediate Cause (Final disease or condition resulting in death)  Sequentially list currolliums, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1  Yes   | a  | as a consequence of):  Left as a consequence of):  Left as a consequence of):  Left as a consequence of):  Left as a consequence of):  | CAVS  CAND  Amely  3   Ectopic pregnancy 5   Other (specify)   | ins/   | ARRIS<br>ARRIS<br>ARRY<br>ELIM   | Cobacco use cont  | te of deliver   | Interval Between Onset and Death   |
| Physician/Medical Examiner                                   | Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes  No 9 Unknown  Part II. Other significant condition   | a  | as a consequence of):  Left as a consequence of):  Left as a consequence of):  Left as a consequence of):  Left as a consequence of):  | CAVS  CAND  Amely  3   Ectopic pregnancy 5   Other (specify)   | ins/   | CAPPOS Q  A CON=5  A CON=5  ECI IMA  230. Did  1 []  24a. Was auto auto                          | 23d. Dai Mo  cobacco use cont  Yes 2 No  an psy psy psy psy psy an 24b. y psy psy psy psy psy psy psy psy psy ps            | te of deliver   | Interval Batwaee Onset and Deat  An 'un t  2)  y  Year  a cause of death bly 4 Unkn sy findings avai pletion of cause  |
| Be Completed by Physician/Medical Examiner                   | Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  | a.  Due to (or a Due to (or a d.)  C.  Due to (or a d.)  23c. If yes, outcon 1 Live birth 4 Pregnant 9 Unknown   | as a consequence of):  Less as | CAVS  CAMP  CAMP  Amacy  3   Ectopic pregnancy 5   Other (specify)   e underlying cause give   | Im  Gran in Part I.  26. Place of E                              | 23e. Did   | 23d. Dai Mo vobacco use cont Yes 2 No an psy (24b. psy (27 No be)   | te of deliver inth literature in the literature | Interval Betwee Onset and Deal Aminut  |
| To Be Completed by Physician/Medical Examiner                | Immediate Cause (Final disease or condition resulting in death)  Sequentially list culturious, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes  No 9 Unknown  Part II. Other significant conditions. | a  | as a consequence of):  Less as | CAVS  CAND  CAND  3   Ectopic pregnancy 5   Other (specify)   e underlying cause grue thent 3   DOA   Other by   Other CAVS  | ren in Part I.  26. Place of Cler: 4 Nursing                     | 23e. Did 1 1 24a. Was auto perfect 1 1 Yes. Death (Check only g Home 5 Resi                      | 23d. Dal Mo  cobacco use cont  Yes 2 No  an 24b. Vanimed? 22 No   | te of deliver<br>inth I   | Interval Between Onset and Death Conset  |
| To Be Completed by Physician/Medical Examiner                | Immediate Cause (Final disease or condition resulting in death)  Sequentially list currently in any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  | a.  Due to (or a D | as a consequence of):  LPF as a consequence of): | CAVS  CAND | yen in Part I.  26. Place of Elect 4 □ Nursing year th?          | 23e. Did 1 24a. Was auto perfet 1 Yes Death (Check only 28d. Describe                            | 23d. Dai Mo  23d. Dai Mo  cobacco use cont  Yes 2 No  an psy  pred? 22 No  dence 6 Oth how injury occurr  Street and Numb   | te of deliver inth I I I I I I I I I I I I I I I I I I I  | y Year  cause of death  bly 4 Unkn  sy findings avail  pletion of cause  2 No  |
| Certification: To Be Completed by Physician/Medical Examiner | Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  | a.  Due to (or a D | as a consequence of):  LEST as a consequence of):  LEST as a consequence of):  as a consequence of):  as a consequence of):  LEST as a consequence of):  as a consequence of):  as a consequence of):  as a consequence of):  Injury  Lest as a consequence of):  LEST  Beta death as time of death as  | CAVS  CAMP  CAMP  3   Ectopic pregnancy 5   Other (specify)   e underlying cause give  thent 3   DOA   Other work  Work  M 1   Camp  M 1 | ren in Part I.  26. Place of Cher: 4   Nursing Yat k? Yes 2   No | 23e. Didd  24a. Was auto perfc 1 yes  Death (Check only 28d. Describe  28f. Location (City or To | 23d. Dai Mo  cobacco use cont  Yes 2 No  an 24b. yasy 22 No  he)  dence 6 Oth how injury occurr  Street and Numb wn, State) | te of deliver inth I ribute to the 3 Proba Were autoprior to complete the state of | Interval Betweer Onset and Death Conset  |
| To Be Completed by Physician/Medical Examiner                | Immediate Cause (Final disease or condition resulting in death)  Sequentially list currently in any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  | a  | as a consequence of):  LEST as a consequence of):  LEST as a consequence of):  as a consequence of):  as a consequence of):  LEST as a consequence of):  as a consequence of):  as a consequence of):  as a consequence of):  Injury  Lest as a consequence of):  LEST  Beta death as time of death as  | CAVS  CAMP  CAMP  3   Ectopic pregnancy 5   Other (specify)   e underlying cause give  thent 3   DOA   Other work  Work  M 1   Camp  M 1 | 26. Place of Iner: 4 Nursing year k? Yes 2 No                    | 23e. Didd  24a. Was auto perfc 1 yes  Death (Check only 28d. Describe  28f. Location (City or To | 23d. Dai Mo  cobacco use cont  Yes 2 No  an 24b. yasy 22 No  he)  dence 6 Oth how injury occurr  Street and Numb wn, State) | te of deliver inth I I I I I I I I I I I I I I I I I I I  | Interval Between Onset and Death Onset and Dea |

|  |                  | _1     | For State Registrer  | State of Ma   |   | artment<br>ertificate | of Heal                        | th and M                          |                                       |                       | 5 L                         | 1958                          |
|--|------------------|--------|--|---|---|-----------------------|--------------------------------|-----------------------------------|---------------------------------------|-----------------------|-----------------------------|-------------------------------|
| Phy  | sician           |        | Decedent's Name (First, Middle, La   | ,   |   |                       |                                |                                   | 2. Date of Deat                       | 1                     |                             | 3. Time of Death              |
|  | edical           | ١.     | Matthias Jo  |   | r   |                       |                                |                                   | Dec.                                  | 6, 2                  | 20°05                       | 7:15 p <sup>M</sup>           |
| Exa  | miner            | 1 '    | a. Facility Name (If not institution, giv  |   |   | 4b. City, T           | own, or Loca                   | tion of Death                     |                                       | 4c. County            | of Death                    |                               |
|  |                  |        | Harford Memor  |   |   | H                     | avre                           | de Gr                             |                                       |                       | Harf                        |                               |
| Fune<br>Direc  |                  |        | 040 04 5555  | M 2□F   | (In yrs. last birthday Yrs.                 |                       | Days Hou                       | nder 24 Hrs.<br>urs Min.          | 8. Date of Birth<br>(Month, Day,      | Year)                 | 9. Birthpl<br>Count         | ace (State or Foreign<br>(ry) |
|  |                  |        | Jsual Residence of Decedent  |   | 01  |                       |                                |                                   | Feb. 24                               | , 1921                |                             | MD                            |
| death with the Maryland<br>ms 23a or 28e-f show  |                  |        | 0a. State 10b. County MD Anne  | Arundel   | 10c. City, Town or L                        |                       | 1.7                            |                                   |                                       |                       | 10                          | d. Inside City Limits         |
| he M.  | scto             |        |  | At dilder   |   | Α.                    | rnold                          |                                   |                                       |                       |                             | 1 ☐ Yes 2 🛣 No                |
| with t   | Funeral Director |        | 0e. Street and Number  |   |   | 10f. Zip 0            | ode                            |                                   | 10                                    | g. Citizen of         | What Count                  | ry?                           |
| leath  | era              | -      | 935 Juliet Lane  1. Marital Status   | 12. Was Decedent Ev   | ros in II C 40                              | Min B                 | 2101                           | 2                                 |                                       |                       | USA                         |                               |
| ē # 3  | 듄                |        | 1 ☐ Never Married 2 ☐ Married  | Armed Forces?  1    Yes 2   No  |   | If Yes, specif        | nt of Hispanic<br>y Cuban, Mex | c Origin? (Spe<br>kican, Puerto l | cify Yes or No-<br>Rican, etc.)       |                       | e - America<br>ck, White, e |                               |
| 0036<br>hours after<br>turel', or Ite  | ۵                |        | 3 XWidowed 4 ☐ Divorced  | If Yes, Give<br>Year or Dates:  | WWII  | 1 ☐ Yes 2             | ⊉No Spe                        | cify:                             |                                       | Specify               | w: Wh                       | nite                          |
| 72 hg  | Completed        |        | 15. Decedent's Ec  | lucation  | 16a. Dece                                   | dent's Usual          | Occupation                     |                                   | 1                                     | 6b. Kind of Bu        | usiness/Indi                | ustrv                         |
| 2121<br>d within<br>giene.   | Jan              | -      | Elementary/Secondary (0-12)  | College (1-4or 5+)  |   |                       |                                | most of workin                    | ng                                    |                       |                             | ,                             |
| Maryland 21215-0036 d 2 should be filed within 72 hours aff th and Mental Hygiens. To Is marked other then "neturel", or frequentic event, the Medical Eres.   | S                |        | 11   |   | LOI   | ng Shoi               | 777                            |                                   |                                       |                       | ippi                        | ng                            |
| and the filed not help of the other sevent.  | Be               |        | <ol> <li>Father's Name (First, Middle, Last)</li> <li>Matthias Sacred</li> </ol>   | Heart Kochl   | lor   |                       |                                |                                   | (First, Middle, M.                    |                       | ne)                         |                               |
| faryland 2 should be and Mental Is marked o  | 2                |        | 19a. Informant's Name/Relationship (7  |   |   |                       |                                |                                   | thá Heir                              |                       |                             |                               |
| Ma<br>Ind 2 s<br>alth an<br>27 Is  |                  | 1      | John P. Koehler/   |   |   |                       |                                |                                   | Route Number,                         |                       |                             |                               |
| Baltimore, Maryls permit. Pages 1 and 2 should Department of Health and Mer Importent: If item 27 is marke eny injury or other treumatic   |                  | -2     | 0a. Method of Disposition  | 5011  | 20b. Place of Disp                          | osition (Name         | of Sil                         |                                   | od Road,                              |                       |                             |                               |
| Baltimore, permit. Pages 1 au Department of Hea mportent: If item my injury or othe  |                  |        | 1X Burial 2 ☐ Cremation 3 ☐ 14 ☐ Donation 5 ☐ Other (Specify   |   | 20b. Place of Dispersion Compterly, cre     |                       |                                | Dec.                              | 9.                                    | oc. Location -        |                             |                               |
| Baltim permit. Pa Department Importent eny injury  | oi               | 1 2    | 21. Signature of Funeral Service Licen   |   | Holy Cr                                     |                       |                                |                                   |                                       | Baltimo               |                             |                               |
|  | ouce             | 1      | 23a. Part1. Enter the disease, or comp   | ller  |   |                       | • 11100                        | 711TC 114A                        | A. Sever<br>y, Sever                  | na Par                | k Fun<br>k, MD              | eral Home<br>21146            |
| Wedic Examination of the purish transit the burial-transit the burial-transit was the purish the burial-transit the burial-transit the burial-transit was the burial-transit the burial- | al               | o C ti | disease or condition esuiting in death)  dequentially list conditions, any leading to impose a sussement of the conditions of the conditions of the conditions of the conditions (Disease or injury nat initiated events esuiting in death) Last | b. Due to (or as a co   | iorisequence or):                           | THE C                 |                                | 11500                             | ism                                   |                       |                             |                               |
| the death certification of the attending of the death of  | Physiclan/Medic  |        | F FEMALE: 3b. Was decedent pregnant in the past 12 months? 1 Yes 2 No  | aa.  23c. If yes, outcome of 1 □ Live birth 2 [ 4 □ Pregnant at tim 9 □ Unknown | Fetal death 3                               | Ectopic pregi         |                                |                                   |                                       | 23d. Date<br>Mon      | of delivery                 | ay Year                       |
| S, F, Fres that igned b  | þ                | P      | art II. Other significant conditions co  | ntributing to death but r   | not resulting in the u                      | nderlying caus        | e given in Pa                  | ırt I.                            | 23e. Did tobac                        | co use contri         | bute to the                 | cause of death?               |
| KECOTGS, he law requires t e has been signe tge 2 should be c  | Completed        | -      | CAKONIC NENTIC   | MEUR  |   |                       |                                |                                   | 1 🗆 Yes                               | 2 🗆 No                | 3 🗌 Probab                  | ly 4 Inknown                  |
| Hec<br>He law<br>has b   | nple             | _      |  |   |   |                       |                                |                                   | 24a. Was an autopsy                   | 24b. W                | ere autops                  | findings available            |
|  | Co               |        |  |   |   |                       |                                |                                   | performed                             | d?   de               | eath?                       | letion of cause of            |
| OI VITALITY Physicien: The this certificate ald director, page   | Be               | 2      | Was case referred to medical examiner?   | Inih-t  |   |                       |                                | ace of Death (                    | Check only one)                       |                       |                             |                               |
| Phys C   | 2                | 2      | 1 ☐ Yes No  '. Manner of Death   | lospital:   | 2 ER/Outpatien                              |                       | Other: 4                       |                                   | e 5 🗆 Residenc                        |                       |                             |                               |
| l or Attending after death.  Director: After in by the funer   | Certification:   | -      | 1 Natural 5 ☐ Pending  | 28a. Date of Injury<br>(Month, Day Ye   | 28b. Time of Injury                         | 1.0                   | Injury at<br>Work?             |                                   | d. Describe how                       | njury occurre         | d                           |                               |
| l or Attendiater death. Director: A in by the fu   | fica             |        | 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be  | 28e. Place of Injury  | - At home farm etc.                         | M                     | 1 Yes 2                        | -                                 | 4 1                                   |                       |                             |                               |
| after after d in by  | erti             |        | 4 Homicide determined  | building, etc. (S   | Specify)                                    | et, ractory, or       | rice                           | 28                                | f. Location (Stree<br>City or Town, S | t and Numbei<br>tate) | r or Rural R                | oute Number,                  |
| Hospite<br>4 hours<br>Funerel  | edical C         | 2      | Pa. Certifier Check only one) Certifying Phy   | sician: To the best of mer: On the basis of exand manner stated                 | ny knowledge, death<br>amination and/or inv | occurred at the       | ne time, date<br>my opinion, d | and place, an                     | d due to the caus                     | e(s) and man          | ner as state                | ed,                           |
| To the within 2 To the complet   | Med              | 29     | b. Signature and title of certifier  | and manner stated   | /   |                       | cense numbe                    |                                   |                                       |                       |                             |                               |
| r s ⊢ ŏ  | 1                |        | 1 The  | Ki do   | 1 110                                       |                       |                                |                                   | 29d.                                  | Date signed           | (Menth, Da)                 | r, rear)                      |
|  |                  | 30     | . Name and address of person who co  | Months of death   | (Nam 22a) (T                                | Dei-40                | NYX                            | 300                               |                                       | 121                   | 6/0                         | 51                            |
|  |                  | -      | THOMAS BOALAN  | HILL !  | Ment Line                                   | RAI                   | 465Pi                          | 800<br>1AC                        | HA. Ol                                | 10 64                 | 206                         | (10 210)                      |
| A WES  | tate             | 31     | . Date filed (Month, Day, Year)  | 2. Registrar's  | Signature                                   | ANC                   | 11-1111                        | - /                               | Ill vreg a                            | 6 00                  | MICH                        | 101,210/                      |
| Regis  | strar            |        | DEC 12 2005  | Michael   | K Am  | 161                   |                                |                                   |                                       |                       | /                           | e                             |

12/06/05 1932

Koehler, Hatthias

|                     |  |                      | 1 - For<br>Stete<br>Registrar   |                           | State of                     | Marylan  |                                | artmeni<br>rtificate   |                      |                   |                       | Mental Hy                             | giene                         | 05                         | 41959   |
|---------------------|--|----------------------|---|---------------------------|------------------------------|--|--------------------------------|--|----------------------|-------------------|-----------------------|---------------------------------------|-------------------------------|----------------------------|---|
| ±,                  | Physic   | i sk                 | 1. Decedent's Name (First, Mi   |                           |                              |  |                                |  |                      |                   |                       | 2. Date of De<br>Month                |                               | Year                       | 3. Time of Death                                  |
|                     | /Medi  |                      | Claude Thom   |                           |                              |  |                                |  |                      |                   |                       | Decemi                                | ses 18                        | 200                        |   |
|                     | Examir   | ner                  | 4a. Facility Name (If not institu   |                           |                              |  |                                | 4b. City,  |                      | Location          |                       | 1                                     |                               | ounty of De                |   |
| -                   | AS   |                      | Washington 5. Social Security Number  | 6. Sex                    |                              | T. Age (In yrs. i  | ast hirthday                   | If Under   |                      | gerst<br>If Under |                       | 10 D-44 D:                            | 44                            |                            | hington   |
|                     | Funeral<br>Director  |                      | 227-12-4297   | 1 🕸                       | M 2□F                        | 87   | Yrs.                           | Months   | Days                 | Hours             | Min.                  | 8. Date of Bi<br>(Month, Di<br>April  | 7 191                         | 8 A                        | irthplace (State or Foreign<br>Quntry)<br>irginia |
|                     | g  |                      | Usual Residence of Decedent   |                           |                              |  |                                |  |                      |                   |                       | inprin.                               |                               | <u> </u>                   | 11911114  |
|                     | show   | _                    | 10a. State 10b. Cou   | •                         | n ~+ on                      | 10c. City  | r, Town or Lo                  | cation<br>nithsk   |                      |                   |                       |                                       |                               |                            | 10d. Inside City Limits                           |
|                     | Ba-f   | Director             |   | wasiii                    | ngton                        |  | 311                            |  |                      |                   |                       |                                       |                               |                            | 1 Yes 2 □ No                                      |
|                     | with the   | 급                    | 10e. Street and Number  | <b>~</b> .                |                              |  |                                | 10f. Zip   | Code                 | 01.7              |                       |                                       | 10g. Citizer                  |                            |   |
|                     | eath   | era                  | 55 S. Main  |                           | 2 Was Dece                   | dent Ever in U.S   | S 13 1                         | Was Deced  | ent of His           | 217               |                       | peorfy Von or N                       | 14                            |                            | S.A<br>nerican Indian.                            |
| Maryland 21215-0036 | ges 1 and 2 should be filed within 72 hours after death with the Maryland tof Heatth and Mental Hygiene. If item 27 is marked other than "natural", or Items 23s or 28s-f show or other traumatic event, it a Madical Examinal manake inclinity. | Completed by Funeral | 1 ☐ Never Married 2 ☐ M 3 🛣 Widowed 4 ☐ Divorce   | arried                    |                              | ces?<br>2 <sup>No</sup> 42-4                             |                                | f Yes, spec  |                      |                   |                       | pecify Yes or No<br>Rican, etc.)      | 1                             | Black, Wh                  |   |
| 50                  | 72 ho  | ted                  | 15. Decec<br>(Specify only hig  | ent's Educ                | ation                        |  | 16a. Dece                      | dent's Usua  | Occupa               | tion              |                       |                                       | 16b. Kind                     | of Busines                 | s/Industry  |
| 21                  | within<br>ene.<br>than "u  | nple                 | Elementary/Secondary (0-12  |                           | College (1-                  | 4or 5+)  | life.                          | kind of wor.<br>DO NOT us  |                      |                   | t dr won              | king                                  |                               |                            |   |
| 121                 | led w<br>lygier<br>her th  |                      | 8   |                           |                              |  |                                | Mech   |                      |                   |                       |                                       |                               |                            | vernment  |
| anc                 | 12 should be filed within<br>h and Mental Hygiene.<br>7 is marked other than "<br>traumatic event, the Max   | Be                   | 17. Father's Name (First, Midd  |                           | Vina                         |  |                                |  |                      |                   |                       | e (First, Middle                      |                               | ,                          |   |
| 2                   | should<br>ad Me<br>mark<br>matte   | To                   | Willie Ti  19a. Informant's Name/Relatio  |                           |                              |  | 19b Mailir                     | a Addross  | (Stroot a            |                   |                       | a Jenny                               |                               |                            | 7:- 0   |
| <b>S</b>            | and 2 sealth arm 27 is   |                      | Melita Wishar   |                           |                              | ghter)   |                                |  |                      |                   |                       |                                       |                               | iwii, State,               | Zip Code)   |
| ē,                  | f Health<br>f Health<br>item 27  |                      | 20a. Method of Disposition  |                           |                              |  | ace of Dispo                   | sition (Nam  | e of                 |                   |                       | Date                                  | 20c. Locati                   | ion - City o               | r Town, State                                     |
| E C                 | Page<br>nent o<br>nt: If   |                      | 1 X Burial 2 ☐ Crematic<br>4 ☐ Donation 5 ☐ Other   |                           | moval from S                 | lale .   | metery, cren<br>thsbur         |  |                      | 110               | ec.<br>2005           |                                       | Smi+1                         | hsbur                      | ra . Md .   |
| Baltimore,          | permit. Pages 1 and<br>Department of Health<br>Important: If item 27<br>any injury or other tr<br>once.  |                      | 21. Signature of Funeral Servi  | ce License                | 9                            |  |                                | . Name and   |                      | of Facilit        | у                     | 12                                    | 525 B                         | radbu                      | τι Διιο   |
| <u> </u>            | 89 = 28  |                      | 7 John  | oe.                       | Davis                        | MOI  | 414 J.                         | L. Da  | vis                  | Fune              | ral                   | Home Sn                               | nithsb                        | urg,M                      | d.21783   |
| **                  | Physician<br>/Medical<br>Examiner  | ner                  | 23a. Part1. Enter the disease, shock, or heart failure. L Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury) | ist only one              | Due to (o                    | r as a consequ   | pny<br>ence of):               | AV2  | TEA                  | 29                |                       | ) (SEA                                |                               |                            | Approximate Interval Between Onset and Death      |
| 15                  | ecute<br>and<br>-trans   | Examiner             | Cause (Disease or injury that initiated events resulting in death) Last   | <b>)</b> c.               |                              |  |                                |  |                      |                   |                       |                                       |                               |                            |   |
| 8760,               | be executed<br>sician and<br>burial-transit  |                      | Totaling in double Last   |                           | Due to (o                    | r as a consequ   | ence of):                      |  |                      |                   |                       |                                       |                               |                            |   |
| 687                 | physicate sthe l   | dlcal                |   | d.                        |                              |  |                                |  |                      |                   |                       |                                       |                               |                            |   |
| P.O. Box (          | The law requires that the death certificate be executed to has been signed by the attending physician and bage 2 should be detached for use as the burial-transit  | Physician/Me         | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown   | 23                        | 1 ☐ Live bir                 | ome of pregnar<br>th 2   Fetal<br>nt at time of de<br>vn | death 3                        | Ectopic pre<br>Other (spe  |                      |                   |                       |                                       | 23d.                          | Date of de                 | elivery<br>Day Year                               |
|                     | es thai<br>igned t   | by P                 | Part II. Other significant cond   | tions cont                | ibuting to dea               | th but not resul   | Iting in the ur                | derlying ca  | use giver            | n in Part I.      |                       | 23e. Did t                            | obaceo use o                  | contribute t               | to the cause of death?                            |
| ğ                   | w require<br>been sig<br>should b  | pe                   | DIABele   | ) 11                      | lella                        | his,   | rere,                          | ohere  | AL                   |                   | **                    | 10                                    | Yes 2□N                       | o 3□P                      | robably 4 Unknown                                 |
| of Vital Records,   | The law resate has be page 2 sho   | Completed            | VAJento   | R                         | Dise                         | Ase  | Hy                             | rosli  | pid                  | em.               | iA                    | 24a. Was<br>autor                     |                               | 4b. Were a prior to death? | utopsy findings available completion of cause of  |
| ta                  |  | Ö                    | 25. Was case referred to medi   | V1516                     | N                            |  | - 1                            |  |                      | 00 81             | -( D                  | 1 ☐ Yes                               | 212 No                        | 1 🗆 Yes                    |   |
| <u>&gt;</u>         | Physician:<br>this certific<br>ral director,   | To B                 | examiner?   | -                         | spital: 1 10 for             | patient 2 E  | R/Outpatient                   | 3□ DOA   | Other                | _                 |                       | h <i>(Check only c</i><br>me 5□ Resid |                               | Other (Co.                 |   |
| 0                   |  |                      | 27. Manner of Death 1 Natural 5 ☐ Pen   |                           | 28a. Date of                 |  | 28b. Time of                   |  | c. Injury a<br>Work? |                   |                       | 28d. Describe                         |                               |                            | эспу)   |
| Ö                   | Attending<br>ir death.<br>ector: After<br>by the fune  | atlc                 | 2 ☐ Accident inve   | tigation                  | (ividitar)                   | Day , car,   | Injury                         | М  |                      | es 2 1            | No                    |                                       |                               |                            |   |
| Division            | after de Directe   | Certification:       | 3 ☐ Suicide 6 ☐ Coul<br>4 ☐ Homicide dete   | d not be<br>mined         | 28e. Place o<br>building     | f Injury - At hor<br>g, etc. <i>(Specity)</i>            | ne, farm, stre                 | et, factory,   | office               |                   |                       | 28f. Location (S<br>City or Tox       | Street and Nu<br>vn, State)   | ımber or R                 | lural Route Number,                               |
|                     | To the Hospital or Attendi<br>within 24 hours after death.<br>To the Funeral Director: A<br>completely filled in by the fu   | edical C             | 29a. Certifier  (Check only one)  | ring Physic<br>of Exemine | cien: To the ber: On the bas | is of examination  | rledge, death<br>on and/or inv | occurred a   | t the time           | , date and        | d place,<br>th occurr | and due to the<br>red at the time,    | cause(s) and<br>date and plac | I manner a                 | s stated.<br>e to the cause(s)                    |
|                     | To the within 2 To the complet   | W e                  | 29b. Signature and title of certi   | ier                       | and maning                   | 1 Stated.  |                                | 29c.   | License              | number            | -                     |                                       | 29d. Date sig                 | gned (Mon                  | th, Day, Year)                                    |
| ,                   | /  |                      | / Clu   | 1                         |                              |  |                                |  | 14-                  | 159               | 0                     |                                       | 12/                           | 20/1                       | 05  |
|                     | 5  |                      | 30. Name and address of person  | e of                      | 2291                         | of death (Item   | 23a) (Type, F                  | Srint) Bi  | VD                   | SM.               | m                     | sburg                                 | MO                            | 2                          | 1.783   |
|                     | Sta<br>Registr   |                      | 31. Date filed (Month, Day, Yea   |                           |                              | gistrar's Signatu  | ire do                         | A STATE OF THE PARTY OF THE PAR |                      |                   |                       |                                       |                               |                            |   |
| DH                  | MH 17 Pay 1/2  |                      | DEC 2   | 8 200                     | Jude                         | THE TO   |                                |  |                      |                   |                       |                                       |                               |                            |   |

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician KYUNG Month Dav Year 2005 /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Shady Grove Adventist Hospital Rockville Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1**X**M 2□F Director 348-52-1581 Apr 21, 1941 Korea Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location r than "natural", or itams 23a or 28a-f show tre Medical Examiner must be notified at 10d. Inside City Limits Director 1 Yes 2 No Maryland Montgomery

10e. Street and Number Gaithersburg 10f. Zip Code 10g. Citizen of What Country? death with Funeral 381 West Side Dr 20878 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or liamany injury or other traumate. Black, White, etc. 1 Yes 2 No If Yes, Give X Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: <u>^</u> 3 ☐ Widowed 4 ☐ Divorced Asian Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Marriage Counselor Self Employed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Dong-Il Kim <u>Gab Soon Lee</u> 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lila Kim/Daughter 206 Midsummer Dr, Gaithersburg, MD 20878 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Dec 9, 2005 Norbeck Memorial Olney, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hines-Rinaldi Funeral Home Miplin 11800 New Hampshire Ave, Silver Spring, MD 20904 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician HSDICATION /Medical Due to (or as a consequence of): Examiner Metastatu Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed burial-transit the attending physicien and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical use as the IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ò in the past 2 months? 1 ☐ Yes 2 ☑ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9□ Unknown 9 Unknown à Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ page 2 should be Completed 1 Tyes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? /es 2 ☑ No this certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director. Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: Inpatient Cther: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 No 2 ER/Outpatient 3□ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) Certification: 28b. Time of 28d. Describe how injury occurred Injury at Work? Natural 5 Pending investigation 1 Tyes 2 □ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 63263 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9901 Medical Center Drive, Rockville MD 20850 MORSLI 31. Date filed (Month, Day, Year) 2. Registrar's Signature State DEC 2005 Registrar

05-8565 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Items: 23a part I.II.27.28a,b,c,d,e,f,per MEO.G-851.1/21/06 reb State of Maryland 7 Department of Health and Mental Hygiene B.K.S Unpend CARL G. LONG 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 18, 2005 Year DEC. **Physician** 1738 P ™ Carl Glen Long /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner WASHINGTON WASHINGTON COUNTY HOSPITAL HAGERSTOWN If Under 1 Year | If Under 24 Hrs. | 5. Social Security Number Sex 1X M 2□F 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year)
May 27, 1961 Birthplace (State or Foreign Country) **Funeral** Days Months Hours Yrs. Virginia Director 219-68-8893 Usual Residence of Decedent Maryland 10c. City, Town or Location 10b. County 10d. Inside City Limits or 28e-f ehow the Modical Exerciner roust be notified at Yes 2□No Director Hagerstown Maryland Washington 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Items 23a 631 West Franklin Street 21740 U.S.A. Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No If Yes, Give X Year or Dates: 6 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: Specify: White 3 Widowed 4 Divorced 'natural', 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Landscaping & Farming Elementary/Secondary (0-12) College (1-4or 5+) Landscaper/Farmer i. Pages 1 and 2 should be filed with the properties of the proper 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Orpha Helen Keller Oscar Richard Long 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Richard C. Long, Sr. - Brother 222 Bennett Court, Thurmont, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If Ite
eny injury or ot 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Pine Grove Cemetery 12/22/05 Mount Airy, Maryland 4 □ Dipration 5 □ Other (Specify) 21. Signa ure of Funeral Service Licenspe 22. Name and Address of Facility Molesworth-Williams P.A., Funeral Home Hores d 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 20872 Immediate Cause (Final disease or condition resulting in death) Oxycodone intoxication Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to for as a consequence off Examiner or Attending Physicien: The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last attending physician and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 by Physician/Medical 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐ Pregnant at time of death 5 Other (specify) ed by the detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Hemochromatosis, Chronic Drug Use 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 X Yes 2 □ No 24a. Was an autopsy 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1) Yes 2 □ No 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury Fnd •28b. Time of (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred After 1 Natural 5 Pending investigation efter death. Unknown <sup>M</sup> 1 ☐ Yes 2√2 No 12/18/05 2 Accident Unknown 6 X Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
HOUSE 281. Location (Street and Number or Rural Route Number, City or Town, State) 631 W.Franklin St. filled in by 4 Homicide apt 1, Williamsport, Md. within 24 hours of To the Funerel D completely filled i 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai 29a. Certifier (Check only one) To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 19, 2005 O.C.M.E DEC. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 111 PENN STREET, BALTIMORE, MARYLAND 21201 E. Southail, mD 31. Date filed (Month, Day, Year) 32. Registrar's Signature

Registrar

DEC 2 8 2005

|  | 1 - State of Maryland / Department of Health and Mental Hygiene Certificate of Death  State Registrar  Certificate of Death   |
|--|---|
|  | 1. Decedent's Name (First, Middle, Last)  2. Date of Death  3. Time of Death  |
| Physician  | HENRIETTA MAE LABER LE 14 2005 635 AM   |
| /Medical<br>Examiner   | 4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death  4c. County of Death   |
|  | Coffman Nursing Home Hagerstown Washington  |
| Funeral  |   |
| Director   | 5. Social Security Number 6. Sex 1 Age (In yrs. last birthday) 1 Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign (Month, Day, Year) 1 Age (In yrs. last birthday) 1 Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign (Month, Day, Year) 1 Age (In yrs. last birthday) 1 Under 1 Year If Under 24 Hrs. 1 Days Hours Min. 1 December 21, 1923 Maryland   |
| pu k   | 10.00   |
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| 28a-f  |   |
| after death with the Maryland after death with the Maryland or ltems 23e or 28a-f show nirrer must be notified at Funeral Director   | 40040 TI T  |
| ns 23  | 0.0.7.  |
| fter of the relation of the re | Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  Black, White, etc.   |
| O36  | 3 □ Widowed 4 □ Divorced If Yes, Give 1 □ Yes 2 No Specify: Specify: White  |
| 21215-00 ed within 72 ho ygiene. ygiene "ne rihan "naturn "naturn "naturn "naturn "naturn "ne rihan "naturn "ne medical is "ti in medical  | 15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of work done during most of working  16b. Kind of Business/Industry  |
| 21<br>Ban Ban nple   | Elementary/Secondary (0-12) College (1-4or 5+) Irle. DO NOT use retired) New and Used   |
| ed w ed w ygier tr. II.s   | 12 Sales Office Equipment Office Equipment  |
| be fill had out aven   | 17. Father's Name (First, Middle, Last)  18. Mother's Name (First, Middle, Maiden Sumame)   |
| Yla<br>nould<br>I Men<br>narke<br>natic  | Alvin Hamilton Etta Nave  |
| Mai<br>d 2 st<br>h and<br>7 is n<br>traun  | 19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  RUSSell W. Laber Husband 12919 The Terrace Ext Hagerstown Md 21742   |
| e, lan Healt Healt of ther   | Russell W. Laber Husband 12919 The Terrace Ext., Hagerstown, Md. 21742  20a. Method of Disposition    Date   20c. Location - City or Town, State  |
| nor ages not of  | 1 Burial 2 Cremation 3 Removal from State   |
| Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23e or 28a-1 show any injury or other traumatic avent. The Medical Examiner must be multiled at some.  To Be Completed by Funeral Director   |   |
| Berr Depriment any sang  | 21. Signature of Funeral Service Licensee  R. Kuel Brady  A.K. Coffman Funeral Home, Inc. 40 East Antietam Street, Hagerstown, Md. 21740  |
|  | 23a. Part 1. Enter the disease, or compligations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  Approximate   |
| Physician  | Interval Between Onset and Death disease or condition   |
| /Medical   | resulting in death)  Due to (or as a consequence of):   |
| Examiner   | Sequentially list conditions, b. Middle OBSTMATIR Worg disease 7 & flows  |
| O,  oxecuted in and inal-transit  Examiner   | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events  C. Due to Gas a consequence of):  C. C. C. C. C. C. C. C. C. C. C. C. C. C   |
| 60,<br>be executed<br>ician and<br>burial-transit  | that initiated events resulting in death) Last  Due to (or as a consequence of):  |
| S8760, cate be executed physician and is the buriat-transit  | V   |
|  | d   |
| DX (Certification)   | IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy 23d. Date of delivery   |
| Beath death death death death  | in the past 12 mophs?  1  |
| P.O. Box nat the death certification of the attending letached for use a Physician/M   | 9 Unknown 9 Unknown   |
| ords, P.O. Box 6 requires that the death certific been signed by the attending p should be detached for use as eted by Physician/Mee   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part II. 23e. Did tobacco use contribute to the cause of death?  |
|  | 1 Yes 2 No 3 Probably 4 Gunknown  |
| as b   | 24a. Was an 24b. Were autopsy findings available  |
| Vital Record  vital Record  certificate has been s  rector, page 2 should  | autopsy prior to completion of cause of performed? performed? 1 □ Yes 2 □ No  |
| of Vital of Vital Physician: 1 this certificat ral director, p   | 25. Was case referred to modical examiner? 26. Place of Death (Check only one)  |
| of V<br>Of V<br>Physic<br>rthis c  | 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other. 4 Hoursing Home 5 Residence 6 Other (Specify)   |
| on of oing Physical ding Physi | 27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury 28b. Time of Injury 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Work?  |
| isic<br>death<br>death<br>stor:<br>the   | 2 Accident investigation 3 Suicide 6 Could not be   |
| Division of tell or Attending F is effer death. el Director: After ed in by the tuner?   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  28f. Location (Street and Number or Rural Route Number, City or Town, State)  |
| spite<br>nours<br>nerel  | 29a. Certifier  (Check only Check on |
| Division of Vital Re Division of Vital Re To the Hospitel or Attending Physician: The within 24 hours effer death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page  | (Check only one)  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |
| To the within To the comp  | 29b. Signature and title of ceptitier 29c. License number 29d. Date signed (Month, Day, Year)   |
|  | ▶ 71mue (MAN, MI) U36655 Dec. 14 2005   |
| 0.411 ==   | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  324 Enut Antician STAUL Suite 260: HAGILITAKA MD 2171(0)  |
| ₩-5  | 31. Date filed (Month, Day, Year)  32. Registrar's Signature  |
| Registrar  | DEC 15 2005 Klasen D. Speck   |

|                                |  |                | State of Maryland / Dep  | partment of Health and Nertificate of Death   | Mental Hygier                                    | 4 600   | 1963  |
|--------------------------------|--|----------------|--|---|--|---|---|
|                                |  |                | Decedent's Name (First, Middle, Last)  |   | 2. Date of Death                                 |   | 3. Time of Death                                    |
|                                | Physicia<br>/Medic   |                | George Lawrence Lee  |   | December   | 20 2005   | 0139 A M  |
|                                | Examin   |                | 4a. Facility Name (If not institution, give street and number)   | 4b. City, Town, or Location of Death  |  | 4c. County of Death                             |   |
|                                |  |                | 1466 Appleton Road   | E1kton  If Under 1 Year   If Under 24 Hrs.  | 0.000  | Cecil   |   |
|                                | Funeral<br>Director  |                | 5. Social Security Number 6. Sex 1 № 1 7. Age (In yrs. last birthda of 1 № 1 1 № 1 1 1 1 1 1 1 1 1 1 1 1 1 1   | Months Days Hours Min.  | 8. Date of Birth<br>(Month, Day, Ye,<br>July 28, | ar) Count                                       | ace (State or Foreign<br>ry)<br>1 Carolina          |
|                                |  |                | Usual Residence of Decedent  |   | July 20, .                                       | 1754   NOTE                                     | i carorina  |
|                                | ryland   |                | 10a. State 10b. County 10c. City, Town or  |   |  | 10  | d. Inside City Limits                               |
|                                | 8a-f s   | Director       | Maryland Cecil Elkton  | <del></del>   | · · · · · · · · · · · · · · · · · · ·            |   | 1 ☐ Yes 2 🕅 No                                      |
|                                | with the   |                | 10.6 Street and Number   | 10f. Zip Code 21921   | 10g.   | Citizen of What Count                           | •   |
|                                | eath   | Funeral        | 1466 Appleton Road  11. Marital Status 12. Was Decedent Eyer in U.S. 13  | 8. Was Decedent of Hispanic Origin? (Sp   | ecify Yes or No-                                 | United Sta                                      |   |
| ယ                              | after d<br>or iten   | 표              | 1 Never Married 2 Married 1 Never Married 2 Married 1 Yes 2 No   | If Yes, specify Cuban, Mexican, Puerto  | Rican, etc.)                                     | Black, White, e                                 | tc.   |
| ğ                              | 72 hours after death with the Maryland<br>Insturat; or Items 23a or 28a-f show<br>dical Examinat mast be notified at   | d by           | 3 ☐ Widowed 4 ☐ Divorced   | 1 ☐ Yes 2 🏋 No Specify:   |  | Specify: Wh                                     | ite   |
| 5-0                            | natu<br>natu   | Completed      | (Specify only highest grade completed) (Gir  | edent's Usual Occupation<br>re kind of work done during most of work<br>. DO NOT use retired) | sing 16b   | . Kind of Business/Ind                          | ustry   |
| 12                             | within<br>ene.<br>than   | dwc            | Elementary/Secondary (0-12) College (1-4or 5+)   | chnician  |  | Railroad  |   |
| d 2                            | illed<br>Hygid<br>other  | Be Co          | 17. Father's Name (First, Middle, Last)  |   | e (First, Middle, Maid                           |   |   |
| /an                            | should be land Mental I smarkad o  | To B           | Earl Lee   | Frances   | Vaughn   |   |   |
| lary                           | 2 short and N is ma  |                |  | iling Address (Street and Number or Rui   |  |   |   |
| ≥,≤                            | is 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hygiene for them 23a or 28a-1 show Item 27 is marked other than "natural", or items 23a or 28a-1 show other treumatic event, the Medical Examinar regains a notified at |                |  | 6 Appleton Road, E  |  | -1  |   |
| Baltimore, Maryland 21215-0036 |  |                | 20a. Method of Disposition  1 Burial 2 Cremation 3 Removal from State Internation  | maphy restricte for Dece  | mber J   | . Location - City or Tov<br>essup,              |   |
| Ιξίπ                           | permit. Page<br>Department of<br>Important: If<br>any injury or<br>once.   |                | 4 Modulation 3 Cottler (Specify)   | elient of redictile 20,   | 2005 Pe  | ennsylvania                                     | 3   |
| Ba                             | permit. Departr Imports any inj  |                | Jones S. Juhr  | 22. Name and Address of Facility<br>Ticks Home for Fund<br>103 W. Stockton Sta                | erals, P.A<br>reet, Elkt                         | on, Maryla                                      | nd 21921  |
|                                |  |                | 23a. Part1. Enter the disease, or complications that caused the death. Do not a shock, or heart failure. List only one cause on each line.                               | nter the mode of dying, such as cardiac   | or respiratory arrest,                           |   | Approximate<br>Interval Between<br>Onset and Death, |
|                                | Physician  |                | Immediate Cause (Final disease or condition resulting in death)  a. Hepatocellu  | lar (arcinor  | na   | .^  | -6 mon 45   |
|                                | /Medical<br>Examiner   |                | Due th (or as a consequence of):   |   |  |   |   |
|                                |  | ē              | Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury  |   |  |   |   |
| H                              | outed<br>d<br>ansit  | Examine        | cause. Enter Underlying Cause (Disease or injury that initiated events  c.   |   |  |   |   |
| 0,                             | e exectian and arrial-tr   |                | resulting in death) Last Due to (or as a consequence of):  |   |  |   |   |
| 8760,                          | death certificate be executed a stending physician and by for use as the burial-transit  | dlcal          | d  |   |  |   |   |
| 9                              | death certific<br>attending pl   | Physician/Me   | IF FEMALE: 23c. If yes, outcome of pregnancy   |   |  | 23d. Date of deliver                            | v   |
| Box                            | atten<br>d for u   | clan           | 1 Vos 3 No. 4 Pregnant at time of death  | B⊟Ectopic pregnancy<br>□ Other (specify)  |  | 1   | Day Year  |
| 0                              | at the de<br>by the de<br>tached   | hysl           | 9 Unknown  |   |  |   |   |
| s, P                           | gned<br>go de  | by P           | Part II. Other significant conditions contributing to death but not resulting in the   | underlying cause given in Part I.   |  | co use contribute to the                        |   |
| ord                            | v require<br>been si<br>should t   | ted            | HEPANNS C  |   | 1 ☐ Yes  | 2⊿No 3 Proba                                    | ıbly 4 □Unknown                                     |
| Vital Record                   | e law r<br>has be<br>je 2 sh   | Completed      |  |   | 24a. Was an autopsy                              | prior to con                                    | sy findings available pletion of cause of           |
| E H                            |  |                | •  |   | performed<br>1 ☐ Yes 2 Ø                         | No death?<br>No 1 ☐ Yes                         | 28 No   |
| VIII.                          | Physicien: The this certificate ral director, pag  | Be             | 25. Was case referred to medical examiner?  1  Yes 2 No Hospital: 1 Inpatient 2 ER/Outpat  | Other   | th (Check only one)                              |   |   |
| of                             | Phys<br>r this<br>sral di  | To :           | 27. Manner of Death 28a. Date of Injury 28b. Time  | of 28c. Injury at   | ome 5 Residence<br>28d. Describe how in          |   |   |
| ion                            | ttending P<br>death.<br>ctor: After i<br>y the funera  | atlor          | 1 ☑Natural 5 ☐ Pending (Month, Day Year) Injur<br>2 ☐ Accident investigation   | / Wark?<br>M 1 ☐ Yes 2 ☐ No   |  |   |   |
| Division                       | l or Attence<br>after death<br>Director:   | Certification: | 3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of Injury - At home, farm, building, etc. (Specify)  | street, factory, office   | 28f. Location (Street<br>City or Town, St        | t and Number or Rural<br>tate)                  | Route Number,                                       |
| Ö                              | Itel or A<br>irs after<br>rel Directed in by   |                |  |   |  |   |   |
|                                | To the Hospitel or Attending within 24 hours after death.  To the Funerel Director: Attention to the Funerel Director or completely filled in by the fune  | Medical        | 29a. Certifier  (Check only one)  1 ☐ Certifying Physician: To the best of my knowledge, de (2 ☐ Medical Examiner: On the basis of examination and/or and manner stated. | ath occurred at the time, date and place, investigation, in my opinion, death occur           | and due to the cause<br>red at the time, date    | e(s) and manner as sta<br>and place, and due to | ated.<br>the cause(s)                               |
|                                | To th<br>within<br>To th<br>comp   | Me             | 29b. Signature and title of certifier  | 29c. License number   |  | Date signed (Month, L                           |   |
| )                              |  |                | Melder ?. Moderacy: M.D.   | 0005922   | 3 VED  | ember 21  | 0,2005  |
|                                | 3+1  |                | 30. Name and address of person who completed cause of death (Item 23a) (Typ Melchor E. Madarang, MD 215 North  | o. Print)<br>Street Suite C Elkto   | M. MP  | 21921   |   |
|                                | Sta<br>Registi   |                | 31. Date filed (Month, Day, Year) DEC 2 8 2005  A Registrar's Signature  | of Print)<br>Street Swife C Elkh  |  |   |   |

|          |   |                | 1 100  | State of I                        |  | d / Den                    |                          |                            |                         |                             | -                            |                | -cgibic.                   |  |   |
|----------|---|----------------|--|-----------------------------------|--|----------------------------|--------------------------|----------------------------|-------------------------|-----------------------------|------------------------------|----------------|----------------------------|--|---|
|          |   | •              | For<br>State<br>Registrar  | Oldie of I                        | ivial y lai                              |                            |                          |                            | Death                   |                             |                              | Reg No.        | 105                        | 1.1951   |   |
|          |   |                | Decedent's Name (First, Midd)  | le, Last)                         |  |                            |                          |                            |                         | 2                           | . Date of De                 | ath            | <i>J</i>                   | 3. Time of Death                                   | - |
|          | Physicia  |                | CHARLES RI   | CHARD LU                          | JECK,                                    | SR.                        |                          |                            |                         | ]                           | Month<br>DECEMB              | ER 10          | Year<br>Oth 200            | 05 15:00 M   |   |
|          | /Medic<br>Examin  |                | 4a. Facility Name (If not institutio   |                                   |  |                            | 4b. City                 | , Town, or                 | Location o              | of Death                    |                              | 4c. (          | County of Dea              |  |   |
|          |   | X.             | Memorial Hospit  | cal                               |  |                            | Cu                       | mberl                      | Land                    |                             |                              | A.             | llegany                    | У  |   |
|          | Funeral   |                | 5. Social Security Number  | 6. Sex 7.<br>1 □ <b>X</b> M 2 □ F |  | last birthday,             | If Under                 | or 1 Year<br>Days          | If Under :              | Min.                        | . Date of Bir<br>(Month, Da  | th<br>y. Year) | 9. Bi                      | rthplace (State or Foreign ountry)                 |   |
| . 2      | Director  | ļ              | 219–14–6158 Usuaf Residence of Decedent  | I ZV. S. T.                       | 79                                       | Yrs.                       |                          |                            |                         | 1                           | 10V. 1                       | 8,192          | 26 M                       | ARYLAND  | _ |
|          | land  | ł              | 10a. State 10b. County   | ,                                 | 10c. Cit                                 | ty, Town or L              | ocation                  |                            |                         |                             |                              |                |                            | 10d. Inside City Limits                            | - |
|          | Mary  | ţō             | WV MIN   | NERAL                             | R  | IDGEL                      | EY                       |                            |                         |                             |                              |                |                            | 1 □ Yes 2 XNo                                      |   |
|          | death with the Maryland ms 23a or 28e-f ehow r must be notified at  | Director       | 10e. Street and Number   |                                   |  |                            | 10f. Z                   | ip Code                    |                         |                             |                              | 10g. Citiz     | en of What C               | ountry?  |   |
|          | th with   | a D            | ROUTE 1, BO  | OX 559-E                          |  |                            | 2                        | 2675                       | 3                       |                             |                              | U.             | S.A.                       |  |   |
|          | ems E   | Funeral        | 11. Marital Status   | 12. Was Decede<br>Armed Force     | ent Ever in U                            | .S. 13.                    | Was Dec                  | edent of H                 | ispanic Origin, Mexican | gin? (Speci<br>n, Puerto Ri | fy Yes or No<br>can, etc.)   | - 1            | 4. Race - Am<br>Black, Whi |  |   |
| 2        | or It   |                | 1 Never Married 2 Mar  | ried 1 □X/es 2<br>If Yes, Give    | □ No                                     | _                          | 1 🗆 Yes                  |                            | Specify:                |                             |                              | 1              | Specify: WH                |  |   |
| Ś        | within 72 hours after<br>ene.<br>than "naturel", or Ite<br>be Medical Examine   | ed by          | 3 Widowed 4 Divorced   | Year or Date                      | s: WWI                                   | 16a. Dece                  | dent's He                | ual Occup                  | ation                   |                             |                              |                | of Business                |  | _ |
| מ        | n 72<br>"nai  | lete           | (Specify only highe  | est grade completed)              |  | (Give                      | kind of w                | rork done d<br>use retired | during most             | t of working                | ,                            | 100. Kii       | IO OI BUSINESS             | y moustry  |   |
| 7 7      | filed withir<br>I Hygiene.<br>other then  | Completed      | Elementary/Secondary (0-12)  | College (1-4                      | or 5+)                                   | SCHE                       | MES                      | TECI                       | HNIC                    | IAN                         |                              | U.S.           | . POSTA                    | AL SERVICE   |   |
| 2        | be filed within 72 hours after death with the Marylan Hygiene. It Hygiene. It has "naturel", or Items 23a or 28e-f ehow event, the Medical Examinat must be notified at | Be C           | 17. Father's Name (First, Middle   | Last)                             |  |                            |                          |                            | 18. Mothe               | r's Name (                  | First, Middle                | Maiden :       | Su <i>mame)</i>            |  |   |
| ומוומ    | should be<br>nd Menta<br>marked<br>matic ev   | To B           | PAUL HOWAI   | RD LUECK                          |  |                            |                          |                            | BL                      | ANCHI                       | E IR                         | ENE            | HEIL                       | AND  |   |
| a        | 2 shol  |                | 19a. Informant's Name/Relation   | ship (Type, Print)                |  | 19b. Mail                  | ing Addre                | ss (Street                 | and Numbe               | er or Rural i               | Route Numb                   | er, City or    | Town, State,               | Zip Code)  |   |
| ≥        | and 2<br>Balth<br>n 27 I  |                | MARIE LUECE  | K / WIFE                          |  |                            |                          |                            | X 559                   |                             | RIDGEL                       |                |                            | 753  | _ |
| 9        | of H<br>H Iter  |                | 20a. Method of Disposition 1   Burial 2 □ Cremation                                | 3 □Removal from St                |  | Place of Disponentery, cre | osition (Na<br>matory or | ame of<br>other plac       | (e)                     | 12/11 Da                    | 1 -                          | 20c. Lo        | cation - City o            | r Town, State                                      |   |
| altimor  | permit. Pages 1 and 2 should<br>Department of Health and Men<br>Importent: If Item 27 ts marke<br>eny injury or other treumatic<br>once.                                |                | 4 Donation 5 Other (   | Specify)                          |  | s.v.c.                     |                          |                            | \P                      | 1/4                         | 05                           | FI             | LINTSTO                    | ONE, MD  | _ |
|          | Departimon<br>Importential  |                | 21. Signature of Funeral Service   | Licensee                          |  | 2                          | 2. Name a                | and Addres                 | ss of Facility FUNI     | y<br>ERAL I                 | HOME,                        | P.A.           |                            |  |   |
|          | 20 = 0 a  |                | 23a. Part 1. Enter the disease, of   | · Upchu                           |  | th Danse                   | 202                      | GREE                       | ENE ST                  | CREET,                      | _CUMB                        | ERLAI          | ND, MD                     | 21502  |   |
|          | 95<br>90  |                | shock, or heart failure. Lis   | t only one cause on each          | th fine.                                 |                            |                          |                            | `                       |                             | respiratory a                | 11851,         |                            | Approximate<br>fntervaf Between<br>Onset and Death |   |
|          | Physician<br>/Medical   |                | fmmediate Cause (Final disease or condition resulting in death)                    | a Chro                            |  | bstru                      | ctive                    | 2 Pu                       | Imon                    | ary                         | Dise                         | ase            |                            | years  | _ |
|          | Examiner  |                |  | Due to (or                        | as a consec                              | querice or).               |                          |                            |                         | 7                           |                              |                |                            |  |   |
|          |   | Jer            | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying | b. Due to (or                     | as a consec                              | quence of):                | <u> </u>                 |                            |                         |                             |                              |                |                            |  | - |
|          | cuted   | Examiner       | that initiated events  | <b>S</b> c                        |  |                            |                          |                            |                         |                             |                              |                |                            |  |   |
| Ď,       | be executed<br>ician and<br>burial-transit  |                | resulting in death) Last   | Due to (or                        | as a consec                              | quence of):                |                          |                            |                         |                             |                              |                |                            |  |   |
| 2/00/    | 0 5 0   | llcal          |  | d                                 |  |                            |                          |                            |                         |                             |                              |                |                            |  | _ |
| X OX     | certificat<br>nding phy<br>use as th  | Physician/Med  | IF FEMALE:   | 23c. ff yes, outco                | ma of progn                              | 2004                       | ·                        |                            |                         |                             |                              |                |                            |  |   |
| POX      | death c<br>e attend<br>ed for us  | lan,           | 23b. Was decedent pregnant in the past 12 months?                                  | 1 Live birt                       | h 2 ∐ Feta<br>nt at time of c            | aldéath 3i                 | □Ectopic<br>□ Other (    | pregnancy                  | ′                       |                             |                              | 2              | 3d. Date of de<br>Month    | elivery<br>Day Year                                |   |
| ċ        | the de  | yslc           | 1 □ Yes 2 □ No<br>9 □ Unknown  | 9 Unknow                          |  | 16a(ii 5)                  | □ Other (:               | specify)                   |                         |                             |                              |                |                            |  |   |
| 7.       | res that t<br>igned by<br>be deta   |                | Part II. Other significant condit  | ions contributing to dea          | th but not res                           | sulting in the             | underlying               | cause giv                  | en in Part I            |                             | 23e. Did 1                   | obacco u       | se contribute              | to the cause of death?                             |   |
| S        | requires that<br>leen signed by<br>hould be deta  | d by           |  |                                   |  |                            |                          |                            |                         |                             | 10                           | es 2           | No 3∏F                     | Probably 4 Unknown                                 |   |
| ecoras   |   | lete           |  |                                   |  |                            |                          |                            |                         |                             | 24a. Was                     |                | 24b. Were a                | autopsy findings available                         | _ |
| r        | sician: The law<br>certificate has b<br>irector, page 2 s   | Completed      |  |                                   |  |                            |                          |                            |                         |                             | auto<br>perfo<br>1 ☐ Yes     | ormed?         | death?                     | completion of cause of                             |   |
| VITAI    | an:<br>rtifica<br>tor, p  | 0              | 25. Was case referred to medical   | al                                |  |                            |                          |                            | 26. Place               | of Death                    | Check only                   |                |                            |  | - |
| ><br>0   | > .º D  | To B           | examiner? 1 Yes 2 No   | Hospital: 1 1                     | patient 2                                | ] ER/Outpatie              | ent 3 🗆 E                | Oth Oth                    | er: 4 □ Nu              | irsing Homi                 | e 5 ☐ Resi                   | dence 6        | i □Other (Sp               | ecify)   |   |
|          | ng Ph<br>fter th<br>meral   |                | 27. Manner-of Death 1 ☑Natural 5 ☐ Pend  | 28a. Date of (Month,              | Injury<br>Day Year)                      | 28b. Time of Injury        |                          | 28c. Injur<br>Wor          | y at<br>k?              | 28                          | ld. Describe                 | how infury     | occurred                   |  |   |
| DIVISION | Attending<br>ir death.<br>ector: After<br>by the fune   | catl           |  | tigation                          |  | <u> </u>                   | М                        |                            | Yes 2 🗌                 |                             |                              | -              |                            |  |   |
| Ž        | or Atl<br>after d<br>Direct<br>in by  | Certification: | 4 Homicide deten   | mined 288. Place of               | f Injury - At h<br>J. etc. <i>(Speci</i> | iome, farm, s<br>fy)       | treet, facto             | ory, office                |                         | 28                          | 3t. Location (<br>City or To |                |                            | Rural Route Number,                                |   |
| _        | To the Hospitel or Attending I within 24 hours after death.  To the Funeral Director: After completely filled in by the funer   |                | 29a, Certifier 1 Certify   | ing Physician: To the b           | est of my kn                             | owledge dea                | th occurre               | d at the time              | ne date an              | nd place an                 | nd due to the                | Callse(e)      | and mapper                 | as stated  |   |
|          | 24 hc<br>24 hc<br>Fun<br>etely  | Medical        | (Check only 2 Medica one)  | Examiner: On the bas<br>and manne | is of examina                            | ation and/or i             | nvestigatio              | on, in my o                | pinion, dea             | ith occurred                | at the time,                 | date and       | place, and du              | ie to the cause(s)                                 |   |
|          | To the within 2 To the complet  | Me             | 29b. Signature and title of certific   | er                                |  | -1                         | 2                        | 9c. Licens                 | e number                |                             |                              | 29d. Date      | signed (Mor                | nth, Day, Year)                                    | - |
| _        | /   |                | Deven  | grula                             | lh                                       | ~ >                        | 4)                       | Do                         | 544                     | 11                          | 1                            | 1200           | nhac                       | 2005   |   |
| 9        | (IUA  |                | 30. Name and address of person   | who completed cause               | of death (Ite                            | m 23a) (Type               | Print)                   | -                          |                         | ` (                         |                              | ا              |                            |  | _ |
|          | MAN   |                | Beverly M.Ca   | ikins, M.D.                       | 500                                      | Memo                       | rial                     | Ave                        | uns'(                   | jump                        | edan                         | 9 W            | D 312                      | 707  | _ |
|          | Sta<br>Registr  |                | 31. Date filed (Mo)th, Day, Year   | 2005 37 Rec                       | gistrar's Sign                           | aryre                      | and I                    |                            |                         |                             |                              |                |                            |  |   |
|          | 1001011   | - 1            | 111 U = U  |                                   |  | - 1                        |                          |                            |                         |                             |                              |                |                            |  |   |

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Mary Lehman December 14, 2005 10:14 A /Medical 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Frostburg Village Nursing Home Frostburg Allegany If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Days 1 ☐ M 2 🙀 F Months Hours Director 89 214-07-2190 05/15/1916 Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits "naturel", or Items 23a or 28a-f show edical Examirer must be notified at 1 X Yes 2 No Director Allegany Cumberland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 817 Shriver Avenue Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: Completed by I Specify 3 XWidowed 4 □ Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. event. If a Me Elementary/Secondary (0-12) College (1-4or 5+) 8 Homemaker Home other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be permit. Pages 1 and 2 should be fit Oppartment of Health and Mental I Importent: If item 27 is marked ot any injury or other treumetic even QDGS. Brookman George Bessie 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Rosemary Lehman / daughter 817 Shriver Avenue, Cumberland, Maryland 21502 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State \* 4 ☐ Donation 5 ☐ Other (Specify) MD Vet. Cem. @ Rocky Gap 12/19/2005 Flintstone, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Adams Family Funeral Home, P.A. 404 Decatur Street, Cumberland, Maryland 21502 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Vernent Advanced 2 years /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner To the Hospital or Attending Physicien: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Box 68760, the attending physician Physician/Medical the IF FEMALE: use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No jo Day Year 4☐Pregnant at time of death 5 Other (specify) P.0. Š signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 0**9**60 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy this certificate 1 Yes 2 XN0 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 1 ☐ Yes 2 No Cther: 4 X Nursing Home 2 2 ER/Outpatient 3 DOA 5 ☐ Residence 6 ☐ Other (Specify) uneral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: After 1 Natural 5 Pending investigation death. 1 Yes 2 No hours after death, unerel Director: A 2 Accident 6 Could not be 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, lactory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a To the Funerel C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) workers 2 D0055325 December 14, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) mas Wonsock Shin, M.D., 48 Tarn Terrace, Frostburg, Maryland 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar DEC 1 6 2005

|                     |  |                | 1 - For<br>State<br>Registrar  | State of I  | Maryland           |                                | ertment of H                                  |                                    |  | giene                                     |                           | 1966                                      |
|---------------------|--|----------------|--|---|--------------------|--------------------------------|---|------------------------------------|--|---|---------------------------|---|
|                     | Dhomisi  |                | 1. Decedent's Name (First, Middle, La  | est)  |                    |                                |   |                                    | 2. Date of De<br>Month                     | ath                                       | ear                       | 3. Time of Death                          |
|                     | Physici<br>/Medic  |                |  | Samuel Fra  | ncis Llev          | vellyn                         |   |                                    | Decer                                      | nber 09, 2005                             | 5                         | 9:00 P. M                                 |
|                     | Examin   | er             | 4a. Facility Name (If not institution, gir   |   |                    |                                | 4b. City, Town, or                            |                                    |  | 4c. County of I                           |                           |   |
|                     |  |                |  | wer Georges   | Age (In yrs. Ia    |                                | If Under 1 Year                               | Lona<br>If Under 24 H              |  |   | Allega                    | any<br>ace (State or Foreign<br>y)        |
|                     | Funeral Director   |                |  | 1 <b>½</b> ′M 2□F                                     | 72                 | Yrs.                           | Months Days                                   | Hours Mi                           | n. (Month, Oa                              | iy, Year)<br>2, 1933                      | Countr                    | laryland                                  |
|                     | P .  |                | Usual Residence of Decedent  |   | 100 6:5:           | . Town or Lo                   |   |                                    |  |   |                           |   |
|                     | ehov   | <u> </u>       | 10a. State 10b. County  Maryland All   | egany   | Toc. City,         | , rown or Lo                   |   |                                    | ~  |   | 100                       | d. Inside City Limits 1 ☐ Yes 2 XNo       |
|                     | 289-f  | Director       | 10e. Street and Number   |   |                    |                                | 10f, Zip Code                                 | onaconing                          | 8  | 10g. Citizen of Wha                       | at Countr                 | v?  |
|                     | 3a or  |                | 15550 Lower (  | Georges Cree  | k Road             |                                |   | 21539                              |  |   | J.S.A.                    | •   |
|                     | death  | Funeral        | 11. Marital Status   | 12. Was Decede  | ent Ever in U.S    | 6. 13.                         | Was Decedent of Hi<br>f Yes, specify Cuba     | spanic Origin?                     | (Specify Yes or No                         |   |                           | n Indian,                                 |
| 36                  | or Ita   | by Fu          | 1 Never Married 2 Married  | 1 (PYes 2)  | □ No               | ŀ                              | 1 ☐ Yes 2 🛣 No                                | Specify:                           | 0.10 7 7000.7                              | Specify:                                  |                           |   |
| Ö                   | 72 hours after death with the Maryland<br>Insturat; or Itams 23a or 28e-f ehow<br>disal Examinat must be rediffed at   | q pe           | 3 Widowed 4 Divorced  15. Decedent's E   | Year or Date  | es:                | 16a Decer                      | dent's Usual Occupa                           | tion                               |  | 16b. Kind of Busin                        |                           | White                                     |
| 15                  | n "na  | plet           | (Specify only highest gr   | ade completed)  | F.()               | (Give                          | kind of work done a<br>DO NOT use retired,    | uring most of w                    | vorking                                    | TOB. KING OF BUSIN                        | 033/11/00                 | zatry                                     |
| 212                 | filed within Hygiene.  | Completed      | Elementary/Secondary (0-12)  | College (1-4  | 01 3+)             |                                | Ste   | amfitter                           |  |   | Tire                      |   |
| p                   |  | Be             | 17. Father's Name (First, Middle, Las  |   |                    |                                |   | 18. Mother's N                     |  | , Maiden Sumame)                          |                           |   |
| yla                 | should be<br>nd Mental<br>marked o   | 9              |  | Cecil Llewel  | lyn                | 105 14-11                      |   |                                    |  | elen Smith                                |                           |   |
| Maryland 21215-0036 | d 2<br>th a<br>trai  |                | 19a. Informant's Name/Relationship  Edna Llewelly  |   |                    |                                | *   |                                    |  | er, City or Town, Sta<br>naconing, Ma     |                           |   |
|                     | s 1 and 2<br>if Health<br>itam 27 i  | И              | 20a. Method of Disposition   |   | 20b. Pla           | ace of Dispo                   | sition (Name of<br>natory or other place      | 1                                  | Date                                       | 20c. Location - Cit                       |                           |   |
| 9                   | Pages<br>nent of I<br>int: If its<br>iry or o  |                | 1 Surial 2 ☐ Cremation 3 [   |   | ate                | _                              | Memorial Pa:                                  |                                    | December 13, 2005                          | Cumberla                                  | and, N                    | Maryland                                  |
| Baltimore,          | permit. Pages<br>Department of<br>Important: If i<br>any injury or<br>once.  |                | 21. Signature of Funeral Service Lice  | nsee.   |                    | 22                             | . Name and Addres<br>Eichhorn-l               | s of Facility<br>McKenzie          | Funeal Hom                                 | e P.A., 8 East                            |                           |   |
|                     |  |                | 23a. Part . Enter the disease, or con  | plications that cau                                   | sed the death.     | . Do not ent                   | er the mode of dying                          |                                    | coning, Mary                               |   |                           | Approximate                               |
|                     | Physician  |                | sheck, or heart failure. List only<br>Immediate Cause (Final   | one cause on eac                                      | K. 1               |                                | ancer   |                                    |  |   |                           | Interval Between<br>Onset and Death       |
|                     | /Medical   |                | disease or condition resulting in death)   | a<br>Due to (or                                       | as a consequ       |                                | WALE.   |                                    |  |   | 12                        | MUT 4                                     |
|                     | Examiner   |                | Sequentially list conditions.  | b   |                    |                                |   |                                    |  |   |                           |   |
|                     | sit ad   | lue            | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Classe or Kriury that initiated events | Due to (or  | as a consequ       | ence of):                      |   |                                    |  |   |                           |   |
|                     | xecut<br>and   | Examlne        | that initiated events<br>resulting in death) Last  | c. Due to (or   | as a consequ       | ence of):                      |   |                                    |  |   | -                         |   |
| 8760,               | ate be executed thysician and the burial-transit   | dical E        |  | d   |                    |                                |   |                                    |  |   |                           |   |
| 9                   | tificate<br>ig phy<br>as the   | ledic          |  |   |                    |                                |   |                                    |  |   | I                         |   |
| Вох                 | leath certifica<br>attending ph<br>for use as t  | an/N           | IF FEMALE:<br>23b. Was decedent pregnant   | 23c. If yes, outco<br>1□Live birth                    | me of pregnar      |                                | Ectopic pregnancy                             |                                    |  | 23d. Date o                               |                           |   |
|                     | The taw requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit | Physiclan/Me   | in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  | 4□Pregnan<br>9□ Unknow                                | t at time of de    |                                | Other (specify)                               |                                    |  | Month                                     |                           | Day Year                                  |
| P.0                 | that the   |                | Part II. Other significent conditions  | contributing to deat                                  | h but not resul    | fting in the u                 | ndertving cause give                          | n in Part I.                       | 23e. Did t                                 | obacco use contribu                       | ite to the                | cause of death?                           |
| of Vital Records,   | uires tha<br>signed<br>id be dei   | d by           |  | 3   |                    |                                | , <b>g</b> g                                  |                                    | 1 🗆 1                                      | Yes 2□No 3[                               | ] Probat                  | bly 4 Onknown                             |
| S                   | w requ   | lete           |  |   |                    |                                |   |                                    | 24a. Was                                   | an 24b. Wer                               | e autops                  | sy findings available                     |
| Re                  | The tav<br>ate has<br>page 2   | Completed      |  |   |                    |                                |   |                                    | - autop<br>perfo<br>1 ☐ Yes                | rmed? _ dea                               | r to comp<br>th?<br>Yes 2 | sy findings available pletion of cause of |
| ta                  |  | Be C           | 25. Was case referred to medical   |   |                    |                                |   | 26. Place of D                     | eath (Check only o                         |   | 103 2                     |   |
| ) \                 | S S  | 0              | examiner? 1  Yes 2 No  | Hospital: 1 _ Inp                                     |                    | ER/Outpatien                   |   | or: 4 🗌 Nursing                    | Home 5 Resi                                | dence 6 Other (                           | Specify)                  |   |
|                     | ding Ph<br>.r<br>After th<br>funeral   | lon:           | 27. Manner of Death  1. Natural 5 Pending  | 28a. Date of 1<br>(Month,                             | njury<br>Day Year) | 28b. Time of<br>Injury         | Work  | :?                                 | 28d. Describe                              | how injury occurred                       |                           |   |
| Division            | or Attand<br>after death<br>Diractor: /  | icat           | 2 Accident investigation 3 Suicide 6 Could not   | De Dioce of   | Injury - At hor    | me farm str                    | M 1 1   | fes 2 □ No                         | 28f. Location (                            | Street and Number of                      | or Rural                  | Route Number                              |
| Div                 | al or A<br>s after<br>il Dira<br>d in b)   | Certification: | 4 Homicide determined  | building  | , etc. (Specify,   | )                              | oot, tadio, y, omoo                           |                                    | City or To                                 | vn, State)                                |                           | riodio riomoor,                           |
|                     | To the Hospital or Attanding within 24 hours after death. To the Funaral Diractor: After completely filled in by the fune.   | Medical (      | 29a. Certifier 1 Certifying P (Check only one)   | hysician: To the be<br>mine: On the basi<br>and manne | s of examinati     | viedge, death<br>ion and/or in | occurred at the time<br>vestigation, in my op | e, date and pla<br>inion, death oc | ice, and due to the<br>curred at the time, | cause(s) and manne<br>date and place, and | er as stat                | ted.<br>he cause(s)                       |
|                     | To the<br>Within<br>To the   | Me             | 29b. Signature and title of certifier  | / /   |                    |                                | 29c. License                                  |                                    |  | 29d. Date signed (A                       |                           |   |
| )                   |  |                | · //il   | my  | ?                  |                                | D3  | 6766                               |  | Decah                                     | 200                       | 12,2005                                   |
| 5                   | AVA  |                | 30. Name and address of person who VIKRAMalityA  | Pocnai  | of death (Item     | 23a) (Type,                    | Print)  | um boils                           | wed, mo                                    | 21502                                     |                           |   |
|                     | Sta  | ate            | 31. Date filed (Month, Day, Year)  | 32. Reg   | istrar's Signati   | ure                            | , , , ,                                       |                                    | /  | V11-                                      |                           |   |
|                     | Regist   | rar            | DEC 13   | ZUUD  | Carren Carren      | AR                             | Annalls 1                                     |                                    |  |   |                           |   |

|   | 198  | . 2                                 | #4a  1 - State Amend #10e,  Registrar  1. Decedent's Name (First, Middle, Last   |  | per FHD            | Rentifica      | Re Al                                 | Death  |   | Date of D   |                       | 05                   | 5 4                                      | 9 6 7                                    |
|---|--|-------------------------------------|--|--|--------------------|----------------|---------------------------------------|--|---|---|-----------------------|----------------------|--|--|
|   | Physici<br>/Medic  |                                     | Doris K. Lohmeyer  |  |                    |                |                                       |  | Month<br>Decem  | ber Da  | ,<br>10               | 2005                 | 10:50 P <sup>M</sup>                     |  |
|   | Examin   |                                     | 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death  |  |                    |                |                                       |  |   |   |                       |                      |  |  |
| i.  | Funeral<br>Director  | or .                                | 715 Maiden Choice Lane Apt CR H09 Catonsville  5. Social Security Number 214 12 1391  6. Sex 1 M 2XIF 83  7. Age (In yrs. last birthday) Months Days Hours Min.  |  |                    |                | in.                                   | Baltimore  8. Date of Birth (Month, Day, Year)  Mar 20, 1922  Baltimore  9. Birthplace (State or Foil Country)  Maryland |   |   | ace (State or Foreigr |                      |  |  |
|   | U  |                                     | Usuel Residence of Decedent  | 0.   |                    |                |                                       |  | 1.7   | ar 20   | , 10                  | <b>44</b>            |  |  |
|   | ehow   |                                     | 10a. State 10b. County   |  | 10c. City, Town    |                |                                       |  |   |   |                       |                      | 10                                       | 0d. Inside City Limits<br>1 ☐ Yes 2√2 No |
| Maryland 2  | the N<br>28a-f   | rect                                | MD Baltimor  10e. Street and Number  | e  | Catons             |                | Zip Code                              |  |   |   | 10g, Cit              | tizen of \           | What Coun                                |  |
|   | h with   | io i                                | 715 Maiden Choice Lane Apt CR + 108 21228  |  |                    |                |                                       |  |   |   | Unit                  | ed St                | ates                                     |  |
|   | be filed within 72 hours after death with the Marylan Hydisne.  do other then "naturel", or fleme 23a or 28a-1 ehow event, tre Medical Examinar must be notified at  | To Be Completed by Funeral Director | 11. Marital Status  1 Never Married 2 Narried  3 Widowed 4 Divorced  | 12. Was Decedent E<br>Armed Forces?<br>1 Yes 2 N<br>If Yes, Give<br>Year or Dates: | ver in U.S.        |                | cedent of Hi<br>becify Cubar<br>25 No | spanic Origin?<br>n, Mexican, Pu<br>Specify:   | (Specifierto Ric  | y Yes or N<br>an, etc.)   | 0-                    |                      | e - America<br>ck, White, e<br>y:<br>Whi | etc.                                     |
|   | e filed within 72 ho<br>al Hygiene.<br>other then "natur<br>vent, tre Medical  |                                     | 15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  Coflege (1-4or 5+)  16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)  Homemaker   |  |                    |                |                                       |  | 16b. Kind of Business/Industry  Own Home  |   |                       |                      |  |  |
|   | other<br>other   |                                     | 17. Father's Name (First, Middle, Last)  |  |                    | HOLIC          | Haver                                 | 18. Mother's N   | lame (F   | First, Middle   | e, Maiden             |                      |  |  |
|   | should be<br>nd Mental<br>marked o<br>umatic eve   |                                     | Frederick Klages Ella Le   |  |                    |                |                                       |  | <b>Lmate</b>  |   |                       |                      |  |  |
|   | aith and 27 is ma  |                                     | 19a. Informant's Name/Relationship (T) Edwin O. Lohmeyer   | , , ,  |                    | •              |                                       | nd Number or<br>Dice La  |   |   |                       |                      |  |  |
|   | Pages 1 a<br>ent of Hes<br>nt: If Item<br>ry or othe   |                                     | 20a. Method of Disposition  1  | Removal from State   | 20b. Place of D    | Disposition (A | lame of<br>r other place              | 9)   | Date  | •   | 20c. L                | ocation -            | City or To                               | wn, State                                |
| Balt  | permit. Pa Depertmen Important eny Injury  |                                     | 21. Signature of Funeral Service Licens  | = - NH   | 7M01044            | 22. Name       | and Addres                            | s of FacilitHa   | rry   | H. W  | itzk                  | e's                  | Famil                                    | y FH Inc.<br>MD 21043                    |
| P.O. Box 68760, that the death certificate be executed in                 | hysician /Medical xaminer transit to private private transit to the private transit to the private transit to the private transit to the private transit to the private transit to the private transit to the private transit to the private transit to the private transit to the private transit to the private transit to the private transit to the private transit to the private transit to the private transit to the private transit transit to the private transit tr | ai Examiner                         | 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Approximate finterval Between Onset and Death Concern onset and Dea |  |                    |                |                                       |  |   |   |                       |                      |  |  |
|   | death certii<br>e attending<br>id for use a  | Physician/Medical                   | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  | 23c. ff yes, outcome of pregnancy  1   |                    |                |                                       |  |   |   |                       |                      | te of delive                             | ry<br>Day Year                           |
|   | quires that the signed by all the detact   | Completed by                        | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |                    |                |                                       |  |   | bacco use contribute to the cause of death?<br>es 2 No 3 Probably 4 Unknown |                       |                      |  |  |
| al Reco   | The<br>ete h   |                                     | 25 W   |  |                    |                |                                       | - '  | perf<br>1 🗆 Yes   | utopsy prior to completion of cause enormed?                                |                       | npletion of cause of |  |  |
| Division of Vital Records,<br>Lor Attending Physician: The law requires t | ysiclan:<br>is certifice<br>director, p  | o Be                                | 25. Was case referred to medical examiner? 1 ☐ Yes 2 ∑No   | Hospital:  | nt 2 ☐ ER/Outp     | patient 3      | DOA Othe                              | 26. Place of D   |   |   |                       | 6 □Oth               | er (Specify                              | .)                                       |
|   | ttending Phy<br>death.<br>tor: After thi<br>the funeral o  | Medical Certification: T            | 27. Manner of Death  1 SNatural 5 Pending 2 Accident investigation   | 28a. Date of Injury (Month, Day Year)  28b. Time of fnjury Mork?  1 Yes 2 No       |                    |                |                                       |  | 28d. Describe how injury occurred  28f. Location (Street and Number or Rural Route Number, City or Town, State) |   |                       |                      |  |  |
| Divis   | ital or Attend rs after death al Director: led in by the f   |                                     | 3 Suicide 6 Could not be<br>4 Homicide determined  |  |                    |                |                                       | 28f  |   |   |                       |                      |  |  |
|   | To the Hospital or within 24 hours after To the Funeral Direction completely filled in b   |                                     | 29a. Certifier  (Check only one)  29a. Certifier  (Check only one)  Check only one)  Check only one)  Check only one  Check one  Check only one  Check only one  Check only one  Check only on |  |                    |                |                                       |  |   |   |                       |                      |  |  |
|   | To the within 2 To the complet   | Me                                  |  |  |                    |                |                                       |  |   | d (Month, L   | Day, Year)            |                      |  |  |
|   |  |                                     | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Heather D. Mannuel 1 HO 900 Cortin Are Bathr   |  |                    |                |                                       | 6  | p December 12, 2005   |   |                       |                      |  |  |
| )6  | 5  |                                     | 30. Name and address of person who co  | ompleted cause of de   | eath (Item 23a) (T | ype, Print)    | 7 Ave                                 | Balt   | m   | we v  | nb                    | 21                   | 229                                      | •  |
| 1   | ***  | ite                                 | 31. Date filed (Month, Day, Year)  | 32. Registra   | r's Signature      | -0 10          |                                       |  |   |   |                       |                      |  |  |

|  |  |                | Please Type or Prin  |                                   |  |  | •  | •  |   |  |  |
|--|--|----------------|--|-----------------------------------|--|--|--|--|---|--|--|
|  |  |                | 1 - State Of Ma<br>Registrar   |                                   | ertificate of                              | lealth and M<br>Death                          |  | 2005   | 1, 1068   |  |  |
|  |  |                | Hegistrar  1. Decedent's Name (First, Middle, Last)  |                                   | Timodic of i                               | Jean   | 2. Date of Death                               | No.U U J   | 3. Time of Death                                  |  |  |
|  | Physicia   |                | ADELINE M. MC GOVERN   |                                   |  |  | DECEMBER 20,2005 8:40P                         |  |   |  |  |
|  | /Medic<br>Examin   |                | 4a. Facility Name (If not institution, give street and number)   |                                   | 4b. City, Town, or                         | Location of Death                              |  | 4c. County of Dea                                      |   |  |  |
|  |  | ш              | CHARLES COUNTY NURSING   | & REHAB.                          | LA PL                                      | ATA  |  | CHARL  | ES  |  |  |
|  | Funeral<br>Director  |                |  | (In yrs. last birthday<br>9] Yrs. | Months Days                                | If Under 24 Hrs.<br>Hours Min.                 | 8. Date of Birth<br>(Month, Day, Y<br>SEPT. 19 | 9. Bi<br>, 1905 N                                      | rthplace (State or Foreign<br>Country)<br>EW YORK |  |  |
| pu   |  |                | Usual Residence of Decedent  10a. State 10b. County  | 10c. City, Town or L              | onetice.                                   |  |  |  | Table Inside Challimin                            |  |  |
| anyla  | shov   | 7              |  |                                   |  |  |  |  | 10d. Inside City Limits 1                         |  |  |
| the N  | 28a-f  | Director       | MARYLAND CHARLES  10e. Street and Number   | LA PLA                            | 10f. Zip Code                              |  | 100  | Citizen of What C                                      |   |  |  |
| with   | ns 23a or<br>reust be r  |                | 10200 LA PLATA ROAD  |                                   | 206  | 46   | 109  | U.S.A  | •   |  |  |
| death  |  | Funeral        | 11. Marital Status 12. Was Decedent E  | ver in U.S. 13                    |  | ispanic Origin? (Spe<br>in, Mexican, Puerto F  | cify Yes or No-                                | 14. Race - Am  | erican Indian,                                    |  |  |
| after  | or Ite   |                | Armed Forces?  1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 📉 🛪   | ,                                 |  |  | Rican, etc.)                                   | Black, Wh  | ite, etc.   |  |  |
| 5-UUSO<br>72 hours after death with the Maryland | Fra .  | d by           | 3√ Widowed 4 □ Divorced If Yes, Give Year or Dates:  | 1 □ Yes 2√CXNo                    | Specify:                                   | Specify: WHITE                                 |  |  |   |  |  |
| 22 b   | tal Hygiene.<br>d other then "<br>event, the Me  | Completed      | 15. Decedent's Education (Specify only highest grade completed)  | (Giv                              | edent's Usual Occup<br>e kind of work done | durina most of workir                          | 16   | b. Kind of Business                                    | s/Industry  |  |  |
| within   |  | Id I           | Elementary/Secondary (0-12) College (1-4or 5+  | ·) life.                          | DO NOT use retired                         | 1)   |  |  |   |  |  |
| g V  |  |                | 17. Father's Name (First, Middle, Last)  | HOM                               | 1EMAKER                                    | 18. Mother's Name                              | (First, Middle, Ma.                            | OWN SEL  | F   |  |  |
|  |  | o Be           |  |                                   |  |  |  | •  |   |  |  |
| aryla<br>should                                  |  | 2              | PASOUALE CAMPIGLIA  19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, |                                   |  |  |  |  | Zip Code)   |  |  |
| and 2  | aith a<br>27 is<br>r trau  |                | ALICE L. BELL-DAUGHTER   | 2120                              | 1 TYREL                                    | L WAY,LA                                       | ND O'LA  | KES, FL  | 34638   |  |  |
| s 1 a  |  |                | 20a. Method of Disposition   |                                   | osition (Name of<br>ematory or other place |  |  | c. Location - City o                                   |   |  |  |
| mor<br>Pages                                     | not: If i  |                | Maurial 2 ☐ Cremation 3 ☐ Removal from State  4 ☐ Donation 5 ☐ Other (Specify) ☐ Д   | URELWOOD                          |  |  | -05 sm   | ROUDSBU  | RG, PA  |  |  |
| SAITIMO!<br>Sermit. Pages                        | Department of Importent: If eny injury or once.  |                | 21. Signature of Funeral Service Licensee MO   | 0479                              | 22. Name and Addres                        | ss of Facility FUNERAL                         |  |  | ,   |  |  |
| n a  | 2 5 8  |                | Muhwel O. Lon  |                                   | LA PLAT                                    | A. MARYI.                                      | AND 206  | 16   |   |  |  |
|  | hysician<br>/Medical<br>Examiner   |                | 23a. Part1. Enter the disease, or complications the caused to shock, or heart failure. List only one caused neach line                             | ne death. Do not er               | nter the mode of dyin                      | g, such as cardiac or                          | respiratory arrest                             | 10m / Nat 1  | Approximate<br>Interval Between                   |  |  |
|  |  |                | Immediate Cause (Final disease or condition  |                                   |  |  |  |  | Onset and Death                                   |  |  |
|  |  |                | Due to (or as a consequence of):   |                                   |  |  |  |  |   |  |  |
|  |  | _              | Sequentially list conditions, if any, leading to immediate b. Due to (or as a  |                                   |  |  |  |  |   |  |  |
| P b  |  | nlne           | if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury                                     |                                   |  |  |  |  |   |  |  |
| be executed                                      | al-tra   | Examiner       | that initiated events c. Due to (or as a   | consequence of):                  |  |  |  |  |   |  |  |
| / <b>5</b> 0,                                    |  | calE           |  |                                   |  |  |  |  |   |  |  |
| X 08   | g phy<br>as the  | edic           |  |                                   |  |  |  |  |   |  |  |
| DOX  | andin<br>use   | hysiclan/Medl  | IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome o   |                                   | DEstania programa                          |  |  | 23d. Date of de  | 23d. Date of delivery                             |  |  |
| , ë  | this certificate has been signed by th<br>al director, page 2 should be detache                | sicla          | in the past 12 months?  1  |                                   |  |  |  | Month Day Year   |   |  |  |
| . ë  |  | Phys           | 9 Ouknown  |                                   |  |  |  |  |   |  |  |
| <b>S</b>   |  | by             | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                             |                                   |  |  |  | 23e. Did tobacco use contribute to the cause of death? |   |  |  |
| COTOS,<br>w requires                             |  | ted            |  |                                   |  |  |  | 1 Yes 2 No 3 Probably 4 Unknown                        |   |  |  |
| g (t)  |  | ompleted       |  |                                   |  |  | 24a. Was an autopsy                            | prior to   | utopsy findings available completion of cause of  |  |  |
| The T  |  | Cor            | -  | <u> </u>                          |  |  | performed                                      |  | s 2 No  |  |  |
| VITAL  |  | Be             | 25. Was case referred to medical examiner?  1  |                                   | Other                                      | 26. Place of Death                             | ,  |  | -   |  |  |
| Phys o   |  | F              | Nursing Home 5 Hesidence 6 Uther (Special  |                                   |  |  |  |  |   |  |  |
| ding   |  | tlon           | 27. Manner of eath 28a. Date of Injury 28b. Time of 28c. Injury at 28d. Describe h  Natural 5 Pending (Month, Day Year) Injury Work?  M 1 Yes 2 No |                                   |  |  |  |  |   |  |  |
| UIVISION<br>or Attending                         | r deal   | ifica          | 3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injur  | y - At home, farm, s              |  | _  | 8f. Location (Stree                            | t and Number or F                                      | lural Route Number,                               |  |  |
| 5 5  | s after  | Certification: | 4 Homicide determined building, etc.   | (Specify)                         |  |  | City or Town, S                                | itate)   |   |  |  |
| Hospita  | within 24 hours after death.  To the Funerel Director: After completely filled in by the funer | edical         | 29a. Certifier (Check only one)  1 Certifying Physician: To the best of 2 Medical Examiner: On the basis of and manner state                       | examination and/or it             | th occurred at the tim                     | ne, date and place, a<br>pinion, death occurre | nd due to the caus<br>d at the time, date      | e(s) and manner a<br>and place, and du                 | s stated.<br>e to the cause(s)                    |  |  |
| o the  | o the  | Med            | 29b. Signature, and title of certified (   | yu.                               | 29c. Licenso                               | e number                                       | 29d.   | Date şigned (Mon                                       | th, Day, Year)                                    |  |  |
| ĭ  | ≥ ⊢ ŏ  |                | Admit In   |                                   | 177  | 142  | 12   | 12103-   | - /   |  |  |
|  | 1  |                | 30. Name and address of person who completed cause of de-  | ath (Item 23a) (Tyne              | Print)                                     | 7  |  | 1  |   |  |  |
|  | ~/   |                | Sh. It 100 Old line Con  | 's Signature                      | albot.                                     | M  | COBIN  | - 41   |   |  |  |
|  | Sta  | te             | 31. Date filed (Month, Day, Year) Registrar  | 's Signature                      | A.D  |  |  |  |   |  |  |
|  | Registr  | ar             | DEC 2 8 2005 Beneva  | Jr 1900                           |  |  |  |  |   |  |  |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** Eleanor Vera McCarty Dec. 12 2005 0535 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Atlantic General Hospital Berlin Worcester If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🗶 F 200-20-5785 Yrs. Director 80 11-10-1925 PA Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Madical Exercises. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Worcester Berlin tX☐ Yes 2 ☐ No Be Completed by Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? S 10218 Old Ocean City Blvd. #807 21811 O US 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Yes 2X No Specify: White 3XXWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) ĺ2 Clerical Bank 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) John W. Patch Margaret Smiden 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Eleanor Foster 330 William st., Berlin, M.d 21811 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State St.Casimir's Cemetery 12/16/2005 Pittsburgh, PA 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility The Burbage Funeral Home 23a. Party Enter the disease, or complications that caused the beath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 108 William St., Berlin, Md. 21811 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Congestive heart failure
Due tolor as a consequence of): Physician /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): To the Funeral Director: After this certificate has been signed by the attending physician and compistely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Medical Certification: To Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Probably 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an 1 Tyes 2 NO or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Division 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \( \text{Homicide} \) within 24 hours a To the Funeral L 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D53612 12/12/05 es of person who completed cause of death (Item 23a) (Type, Print) Baier Healthway Dr. Berlin MD 9733 MO 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

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| POWER TO A SHARE THOSE PROPERTY AND A SAME AND A SAME TO BE A SAME AND A SAME |            |                                       |        | For State   | State of M              | aryland / I                               |                       | artment of He                                  |                                | d Mental                               | Hygien                   | 1e                       | 11070   |
|--|------------|---------------------------------------|--------|---|-------------------------|---|-----------------------|--|--------------------------------|--|--------------------------|--------------------------|---|
| PAYS CAN PARTY THE SCHOOL STATE CONTROL OF STATE CANCEL CONTROL OF STATE CANCE |            |                                       |        | Registrar   | ast)                    |   | Cei                   | rtificate of L                                 | Jeath                          | 2 Date (                               |                          | CUUD                     | 3 Time of Death                               |
| ## Fundament   No. Policy   No. |            |                                       |        |   | ,                       |   |                       | MAN  | NING                           | Month                                  |                          | •                        | 7   |
| Social Security Number   0.5 page   1.5 pa   |            |                                       |        | ,                                     |                         |   |                       | 4b. City, Town, or                             | Location of D                  |  |                          |                          |   |
| 13. 30 - 10.92   20.0 Feb.     |            |                                       |        |   |                         |   |                       | DA/4:  |                                |  |                          |                          |   |
| 131_01_182   The County   The   |            |                                       |        | 5. Social Security Number 6.  | Sex 7. A                |   |                       |  |                                | Min. (Month                            | i, Day, Yea              | ar) Co.                  | untry)  |
| 150. Chevy Chase   150. Control of North gometry   150. Chevy Chase    |            |                                       | 19     | 131-20-1982   |                         | /6  |                       |  |                                | Marc                                   | h 7,1                    | 929 New                  | York  |
| Research   Labratory   Labra   |            | yland<br>Nor                          |        |   |                         | 10c. City, Tow                            | m or Lo               | cation   |                                |  |                          |                          | 10d. Inside City Limits                       |
| Research   Labratory   Labra   |            | a-1-e                                 | ctor   | Maryland Montgome   | ry                      | Chevy                                     | Cha                   | se   |                                |  |                          |                          | 1 XYes 2 No                                   |
| Research   Labratory   Labra   |            | or 28                                 | Jire   | 10e. Street and Number  |                         |   |                       | 7  |                                | <u> </u>                               | 10g. C                   | Citizen of What Co       | untry?  |
| Research   Labratory   Labra   |            | ath w                                 | rail   | 4506 Dalton Roa   |                         |   |                       |  |                                |  |                          | S.A.                     |   |
| Research   Labratory   Labra   |            | er de                                 | nue    |   | Armed Forces            | ?   | 13.                   | Was Decedent of His<br>f Yes, specify Cubar    | panic Origin'<br>, Mexican, P  | ? (Specify Yes of<br>Juerto Rican, etc | or No-<br>.)             |                          |   |
| Naval Research   Labratory     | 36         | rs aft                                | by F   |   | If Yes, Give            | No  |                       | 1□Yes X□No                                     | Specify:                       |  |                          | Specify:                 |   |
| Research   Labratory   Labra   | Q<br>Q     | 2 hou                                 | ted    | 15. Decedent's E  | ducation                | 16a                                       |                       |  |                                |  | 16b.                     |                          |   |
| Bursal 2 (Micromation 3)   Plannacia from State   Commation 3   Plannacia from State   Commation 5   Other (Speechy)   | 215        | hin 7                                 | pje    |   |                         | 5+)                                       | (Give<br>life.        | kind of work done di<br>DO NOT use retired)    | uring most of                  | working                                |                          |                          |   |
| Bursal 2 (Micromation 3)   Plannacia from State   Commation 3   Plannacia from State   Commation 5   Other (Speechy)   | 2          | or th                                 | Con    |   | 5+                      |   | Phy                   |  |                                |  |                          |                          |   |
| Bursal 2 (Micromation 5)   Chemistry of Johnson 1   Chemistry of John   | ud         | d off                                 | Be     |   | •                       |   |                       |  | 18. Mother's                   | Name (First, Mi                        | ddle, Maide              | ∍n Sumame)               |   |
| Bursal 2 (Micromation 3)   Plannacia from State   Commation 3   Plannacia from State   Commation 5   Other (Speechy)   | ₹          | i Men<br>Men<br>Marke<br>Matic        | To     |   |                         |   |                       |  |                                |  |                          |                          |   |
| Bursal 2 (Micromation 3)   Plannacia from State   Commation 3   Plannacia from State   Commation 5   Other (Speechy)   | Mai        | d 2 st                                |        |   | 535                     |   |                       |  |                                |  |                          |                          | ip Code)                                      |
| Bursal 2 (Micromation 3)   Plannacia from State   Commation 3   Plannacia from State   Commation 5   Other (Speechy)   | e,         | 1 an<br>Heali<br>em 2                 | İŠ     |   | / Wire                  | 20b. Place o                              | f Dispo               | sition (Name of                                | 200                            |  |                          |                          | Town, State                                   |
| Physician Medical Examiner  Ph | <u>o</u> n | ages<br>ant of                        |        |   |                         | '   |                       |  | 1                              |  |                          | ,                        |   |
| Physician Medical Examiner  Ph | 慧          | ortan                                 |        |   | * -                     | _Nation                                   | a L (                 | rematory.<br>Name and Address                  | De of Facility                 | C. 16,05                               | Fn]                      | lls Churc                | ch, Va.                                       |
| Physician Modelal Examiner  To provide the death of the d | ä          | P P P P P P P P P P P P P P P P P P P |        | William (   | Bush                    |   |                       | 5130 Wisco                                     | nsin A                         | Joseph (<br>Ave N L                    | awrei<br>I Wae           | rs Sons,                 | D.C. 20016                                    |
| Physician (Medical Examiner)  The proposed of the proposed of  |            |                                       |        | 23a. Part1. Enter the disease, or con<br>shock, or heart failure. List only | pplications that cause  | d the death. Do                           | not ent               | er the mode of dying                           | , such as car                  | diac or respirato                      | ry arrest,               | Jii I II G COII          | Approximate                                   |
| Sequentially list conditions, and we contributed to the cause of pregnancy that infalled events resulting in death (Last Diversity of the cause of pregnancy that infalled events resulting in death (Last Diversity of the cause of pregnancy that infalled events resulting in death (Last Diversity of the cause of the ca |            | Physician                             |        | Immediate Cause (Final  |                         |   | I R                   | TORY   | DISTE                          | אברנ ז                                 | chy:                     | DAME                     | Onset and Death                               |
| Sequentially ist conditions.    Sequentially ist conditions a consequence of):   |            |                                       |        | resulting in death)   |                         |   |                       |  | .5(5   K                       | 1 3                                    | 31110                    | KOIIL                    |   |
| Susse. Enter Underlying ausse. Enter Underlying hat inflated evenish resulting in death) Last    C   | ı          | LXammer                               | L      | Sequentially list conditions,   |                         |   |                       |  |                                |  |                          |                          | 14 Days                                       |
| Second   S   |            | ted                                   | nine   | cause. Enter Underlying   | Due to (or as           | a consequence                             | 01):                  |  |                                |  |                          |                          | •   |
| Second   S   |            | al-tra                                | xar    | that initiated events   | c<br>Due to (or as      | a consequence                             | of):                  |  |                                |  |                          |                          |   |
| The past 12 months?    Spring   Past  | 260        | e be<br>/sicia                        | call   |   | d.                      |   |                       |  |                                |  |                          |                          |   |
| Section   Sect   | 99         | tificat<br>ng phy<br>as th            |        |   |                         |   |                       |  |                                |  |                          |                          |   |
| Section   Sect   | ŏ          | th cer<br>tendir<br>r use             | an/h   | 23b. Was decedent pregnant  |                         |   | 3                     | Ectopic pregnancy                              |                                |  |                          |                          |   |
| 12/9/05  12/9/05  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  KHALED EL-SHAMI 600 NORTH WOLFE STREET, BALTIMORE, ND 21287.   | о.<br>Ш    | e dea<br>the at<br>ned fo             | sici   | 1 ☐ Yes 2 ☐ No  | 4☐Pregnant a            |   |                       |  |                                |  | -                        | Month                    | Day Year                                      |
| 12/9/05  12/9/05  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  KHALED EL-SHAMI 600 NORTH WOLFE STREET, BALTIMORE, ND 21287.   | <u>.</u>   | hat th<br>d by<br>detach              | Phy    |   | contributing to death i | out not resulting i                       | n tha u               | Idorhija a agusa ajusa                         | in Bost I                      | 220 [                                  | Did tobassa              |                          | the serve of death?                           |
| 12/9105  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  KHALED EL-SHAMI 600 NORTH WOLFE STREET, BALTIMORE, ND 21287   | ds,        | signe<br>d be d                       | d b    |   |                         |   |                       | _  | ım Parti.                      |  |                          |                          |   |
| 12/9/05  12/9/05  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  KHALED EL-SHAMI 600 NORTH WOLFE STREET, BALTIMORE, ND 21287.   | Š          | v requ                                | ete    | · · · · · · · · · · · · · · · · · · ·                                       | 1 103                   |   | 211 IN                | CLA  |                                | _                                      |                          |                          |   |
| 12/9105  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  KHALED EL-SHAMI 600 NORTH WOLFE STREET, BALTIMORE, ND 21287   | Rec        | he lav<br>e has<br>ge 2               | m<br>d |   |                         |   | _                     |  |                                | a                                      | utopsy                   | prior to co              | opsy findings available ompletion of cause of |
| 12/9/05  12/9/05  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  KHALED EL-SHAMI 600 NORTH WOLFE STREET, BALTIMORE, ND 21287.   | ā          | ificate<br>or, pa                     |        | 25. Was case referred to medical  |                         |   |                       |  | 00 81                          | 1 🗆 Y                                  | es 28 N                  |                          | 2□ No   |
| 12/9/05  12/9/05  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  KHALED EL-SHAMI 600 NORTH WOLFE STREET, BALTIMORE, ND 21287.   | Š          | yslcie<br>s cert<br>direct            | 00     | examiner?   | Hospital: 1 Minpati     | ent 2∏ER/Ou                               | utpatien              | Other  |                                |  |                          | 6 □Other (Spec           | (6.4)   |
| 12/9/05  12/9/05  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  KHALED EL-SHAMI 600 NORTH WOLFE STREET, BALTIMORE, ND 21287.   | 2          | ter th                                |        | <u>v</u>  |                         |   | Time of               |  |                                |  |                          |                          | "9)   |
| 12/9/05  12/9/05  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  KHALED EL-SHAMI 600 NORTH WOLFE STREET, BALTIMORE, ND 21287.   | jo         | auth.<br>or: Af<br>he fur             | atic   | 2 Accident investigation  | n                       | ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,   | i ijui y              |  |                                |  |                          |                          |   |
| 12/9/05  12/9/05  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  KHALED EL-SHAMI 600 NORTH WOLFE STREET, BALTIMORE, ND 21287.   | Ξ̈́        | r Att                                 | III    |   | 286. Place of in        | jury - At home, fa<br>c. <i>(Specify)</i> | erm, str              | eet, factory, office                           |                                | 28f. Location<br>City of               | on (Street a             | and Number or Rur<br>te) | al Route Number,                              |
| 12/9/05  12/9/05  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  KHALED EL-SHAMI 600 NORTH WOLFE STREET, BALTIMORE, ND 21287.   |            | urs al urs al liled i                 |        | 00 O 00   |                         |   |                       |  |                                |  |                          |                          |   |
| 12/9/05  12/9/05  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  KHALED EL-SHAMI 600 NORTH WOLFE STREET, BALTIMORE, ND 21287.   |            | P Hos.<br>24 ho<br>Fun.<br>etely f    | dica   | Check only 2   Medical Exa  | miner: On the basis of  | it examination an                         | e, death<br>nd/or inv | occurred at the time<br>restigation, in my opi | , date and pl<br>nion, death o | lace, and due to<br>occurred at the ti | the cause(<br>me, date a | s) and manner as and due | stated.<br>to the cause(s)                    |
| 12/9/05  12/9/05  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  KHALED EL-SHAMI 600 NORTH WOLFE STREET, BALTIMORE, ND 21287.   |            | Fo the<br>within<br>Fo the            | Me     |   |                         |   |                       | 29c. License                                   | number                         |  | 29d. D                   | ate signed (Month        | . Day, Year)                                  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  ICHALED EL-SHAMI 600 NORTH WOLFE STREET, BALTIMORE, ND 21287.  | )          |                                       |        | Khaled cl- ?  | Skon                    | MB  |                       | RES  | -00                            | N                                      |                          | 12/9/05                  | en e  |
| State State Registrar    CHALED EL-SHAMI 600 NORTH WOLFE 5TREET, BALTIMORE, ND 21287.   31. Date filed (Month, Day, Year)   32. Tegistrar's Signature   DEC 13 2005   32. Tegistrar's Signature   DEC 13 2005   32. Tegistrar's Signature   DEC 13 2005   32. Tegistrar's Signature   DEC 13 2005   32. Tegistrar's Signature   DEC 13 2005   32. Tegistrar's Signature   DEC 13 2005   32. Tegistrar's Signature   DEC 13 2005   32. Tegistrar's Signature   32.  |            | *                                     |        | 30. Name and address of person who  | completed cause of      |   |                       | Print)   |                                |  |                          |                          |   |
| State 31. Date filed (Month, Day, Year) 32. Jegistrar's Signature  |            |                                       |        |   |                         |   |                       | FE ZIK   | EET, 1                         | SALTIMO                                | IRE, 1                   | 40.2128                  | 7   |
|  |            |                                       |        |   | 2005 32. Fegisti        | ar's Signature                            | 1                     | ale  |                                |  |                          |                          |   |

State of Maryland / Department of Health and Mental Hygiene

|                     |   |                   |  | State of Marylan  | Certificate  | of Death  | Reg. No.  | 15 1.1971  |
|---------------------|---|-------------------|--|---|--|---|---|--|
|                     | Physic  | ian               | 1. Decedent's Name (First, Middle, Last  |   |  | 2. Date<br>Mon  | of Death<br>th Day                              | 3. Time of Death   |
|                     | /Medi   |                   |  |   | LLER   | DEC.  | 18, 2005  | 9:57AM   |
|                     | Examir  | ner               | 4a. Facility Name (If not institution, give<br>BEVERLY HEALTH  | · ·   |  | 4b. City, Town, or Locetion of HAGERSTOWN   |   | of Death<br>ASHINGTON  |
|                     | <sub>o</sub> Funeral<br>Director  |                   | 5. Social Security Number 6. Se 232-72-9480  Usual Residence of Decedent   | 7. Age (In yrs. 93  | last birthday) If Under 1 Y Months Da  | ear If Under 24 Hrs. 8. Date (Mon 12/8)   | of Birth<br>hth, Day, Year)<br>3/1912           | 9. Birthplace (State or Foreign<br>Country)<br>WEST VIRGINIA                         |
|                     | /land   |                   | 10a. State 10b. County   | 10c. Cit  | y, Town or Location  |   |   | 10d. Inside City Limits  |
|                     | a-fsh   | ţċ                | WV BERKELE   | Y   | FALLING WATE   | ERS   |   | 1 □ Yes 2XXNo  |
|                     | ith with the<br>23a or 28<br>ust be no  | Funeral Director  | 10e. Street and Number<br>2510 BROAD LANE  |   | 10f. Zip Cod<br>254  |   | 10g. Citizen of W                               | Vhet Country?<br>JSA   |
| Maryland 21215-0020 | permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other then "netural", or items 23a or 28a-f show any highly or other traumatic event, the Medical Examination ust be notified at once. | b                 | 11. Marital Status  1XXNever Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced  | 12. Was Decedent Ever in Un<br>Armed Forces?<br>1 ☐ Yes 2 ☐ XVX<br>If Yes, Give<br>Year or Dates: | ,S. 13. Was Decedent If Yes, specify (   | of Hispanic Origin? (Specify Yes<br>Cuban, Mexican, Puerto Rican, et<br>No Specify: | or No-<br>lc.) 14. Race<br>Blac<br>Specify      | e - American Indian,<br>k, White, etc.<br>·· WHITE                                   |
| 5-0                 | netu  | etec              | 15. Decedent's Edu<br>(Specify only highest grad   |   | 16a. Decedent's Usual Oc<br>(Give kind of work do  | ccupation<br>one during most of working<br>tired)                                   | 16b. Kind of Bu                                 | siness/Industry  |
| 121                 | within<br>ene.<br>then  | Completed         | Elementary/Secondary (0-12)  | College (1-4or 5+)  |  | 1EMAK ER  | Ol  | √N HOME  |
| d 2                 | Hygi<br>Hygi<br>other   | Be                | 17. Father's Name (First, Middle, Last)  | 4   | 1.0.   | 18. Mother's Name (First, M   | fiddle, Maiden Surnam                           | θ)   |
| /lar                | uld be<br>Menta<br>rked<br>ric ev   | To B              | WILLIAM A. MILL  | .ER   |  | LUC   | ETTA CANBY                                      |  |
| lar)                | 2 should be filed within and Mental Hygiene. is marked other then "raumatic event, the Me   | ľ                 | 19a. Informant's Name/Relationship (T)   |   |  | reet and Number or Rural Route I  |   |  |
|                     | 1 and<br>Health<br>Sm 27<br>ther to   |                   | WAUNITA E. DELLI 20a. Method of Disposition  |   |  | HILL DRIVE, HA  |   | 4D 21740<br>City or Town, State  |
| Baltimore,          | permit. Pages 1 and 2<br>Department of Health a<br>Important: If item 27 is<br>any Injury or other tra<br>once.   |                   | X☐ Burial 2 ☐ Cremation 3 ☐ F<br>4 ☐ Donation 5 ☐ Other (Specify)  |   | Place of Disposition (Name of Proceedings of Procee | 2005  | RFD HEDGE                                       | ESVILLE, W   |
| Bal                 | permit<br>Depar<br>Impor<br>any Ir<br>once.   |                   | 21. Signature of Funeral Service Licens  | ee A  | 22. Name and Ac<br>BROWN FUN   | dress of Facility<br>ERAL HOME, P.O. BOX  | 821,  |  |
|                     | 18: 10  |                   | 23a Part 1 Enter the disease or comple   | Slown   | 327 W. K.  | ING ST., MARTINSBUR   | G, WV 25402                                     | Approvimate  |
| 1                   | Physician<br>/Medical<br>Examiner   | ı                 | 23a. Part1. Enter the disease, or complishock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in deeth)              | alzhe   | r as a consequence of):  |   |   | Approximate Interval Between Onset and Death   |
| x 68760,            | The law requires that the death certificate be executed ate hes been signed by the attending physician and page 2 should be detached for use as the bunal-transit.  | /Medical Examiner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | 0,  | r as a consequence of):  |   |   |  |
| Box                 | attendation   | clan              | De all Other design  |   |  |   | L. Company                                      |  |
| , P.O.              | ires that the death ce<br>signed by the attendi<br>d be detached for us   | by Physician/     | Part II. Other significant conditions cor  | tributing to death but not rest   | uiting in the underlying cause   | given in Part I. 230.   |   | tribute to the cause of death? 3 ☐ Probably 4 ☑ Unknown                              |
| of Vital Records,   | w requires<br>s been sig<br>2 should be   | Completed b       |  | -   |  |   | Was an autopsy performed?                       | 24b. Were autopsy findings<br>available prior to<br>completion of cause<br>of death? |
| Ä                   | The law<br>cate hes<br>page 2   | E O               |  |   |  |   | 1 ☐ Yes 2 No                                    | 1 ☐ Yes 2 ☐ No   |
| /ita                |   | Be                | 25. Was case referred to medical examiner?   |   |  | 26. Place of Death (Check   |   |  |
| of \                | × 00  | ٦.                | 1 ☐ Yes 2 ☐ No ☐ F   | lospital: 1 Inpatient 2   | ER/Outpatient 3LI DOA  | Other: 4 Nursing Home 5   | Residence 6 Othe                                |  |
| o                   | ding I<br>h.<br>After<br>fune   | tlon              | 1 Natural 5 Pending 2 Accident investigation   | 28e. Date of Injury<br>(Month, Day Year)  |  | njury at 28d. Deso<br>Nork?<br>I □ Yes 2 □ No                                       | ande now injury occurre                         | 9G   |
| Division            | or Attendation after deat Director:   | Certification:    | 3 Suicide 6 Could not be determined  | 28e. Place of Injury - At ho building, etc. (Specify  | me, farm, street, factory, offi  | ce 28f. Local   | tion (Street and Numbe<br>or Town, State)       | er or Rural Route Number,  |
| _                   | To the Hospitel or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certific completely filled in by the funeral director.   | edical C          | 29a. Certifier (Check only one)  | sicien: To the best of my knowner: On the basis of examinat and manner stated.                    | wledge, death occurred at the ion and/or investigation, in m   | e time, date and place, end due to<br>y opinion, death occurred at the t            | the cause(s) and mar<br>time, date and place, a | nner as stated.<br>nd due to the cause(s)  |
|                     | To th<br>withir<br>To th<br>comp  | Me                | 29b. Signature and title of certifier  | a 1. 1.   |  | ense number   |   | (Month, Day, Year)   |
|                     | 2   |                   | Manjon   | forago  |  | D28365  | 12-1  | 8-05   |
|                     | 2   |                   | 30. Name and address of person who co  | empleted cause of death (Item   | 23a) (Type, Print)   | D28365<br>Strut Hage  | . ha. 1 771                                     | 10 010/ 5  |
|                     | Ch  | to                | 31. Date filed (Month, Day, Year)  | 38. Registrar's Signal  | 368 MILL   | street Hage   | 101 mm 19                                       | U 01140.   |
| 15                  | Sta<br>Registr  |                   | DEC 2 8 2005   | 200   | Boseles  | J   |   |  |

DHMH 16 Rev 6/95

|                     |  |                | Registrar  | of Maryland  | / Depa             | <b>delible In</b><br>artment of<br><i>tificate o</i> | Health and M                                    | lental Hygi                                  | Are Legible<br>ene<br>g.n. 05                               | 41972  |
|---------------------|--|----------------|--|--|--------------------|--|---|--|---|--|
|                     | Physic<br>/Med   |                | Decedent's Name (First, Middle, Last)     MARTHA MARUCO  |  |                    |  |   | 2. Date of Death                             | Day Ye  | ar 3. Time of Death 5:00 A M                 |
|                     | Exami  | ner            | 4a. Facility Name (If not institution, give street and n<br>HOMEWOOD NURSING HOME  | umber)   |                    | 4b. City, Town                                       | , or Location of Death                          |  | 4c. County of D   | eath   |
|                     | Funeral<br>Director  |                | 5. Social Security Number 6. Sex 1 □ M 2 ☑ F   | 7. Age (In yrs. last<br>89   | birthday)<br>Yrs.  | If Under 1 Yes<br>Months Day                         |   | 8. Date of Birth<br>(Month, Day,<br>04/01/19 | Year) 9.  | Birthplace (State or Foreign Country)        |
|                     | a-f show   | ctor           | Usual Residence of Decedent  | 10c. City, T   | own or Loc         |  |   |  |   | 10d. Inside City Limits 1   Yes 2 □ No       |
|                     | th with the<br>23a or 28   | ai Director    | 10e. Street and Number 16505 VIRGINIA AVENUE   |  |                    | 10f. Zip Code  |   | 10   | g. Citizen of What  |  |
| 9036                | hours after death with the Maryland<br>turel', or Items 23a or 28a-f show<br>al Examiner must be notified at   | by Funeral     | 11. Marital Status 12. Was De  | <b>2XQ</b> (No<br>ive  | l II               | Vas Decedent o                                       | Hispanic Origin? (Spe<br>ban, Mexican, Puerto I | cify Yes or No-<br>Rican, etc.)              | Black, W  | merican Indian                               |
| Maryland 21215-0036 | within 72<br>ane.<br>then "nat   | Completed      | 15. Decedent's Education (Specify only highest grade completed Elementary/Secondary (0-12)  College  | )<br>(1-4or 5+)  | (Give k<br>life. D | ONOT use retii                                       | a during mant of warding                        | ng 16  | 3b. Kind of Busine  |  |
| and 2               | be filed<br>htal Hygi<br>od other<br>event, t  | To Be Co       | 17. Father's Name (First, Middle, Last)  JOSEPH ROSSO  |  | HOME               | MAKER  | 18. Mother's Name                               |  |   | IC   |
|                     | d 2 shouth and N 7 is mai  | F              | 19a. Informant's Name/Relationship (Type, Print) CAROL GOSNELL/DAUGHTER  |  |                    |  | and Number or Rura                              |  | City or Town, State   | o, Zip Code)                                 |
| Baltimore,          | 95 = 5   |                | 20a. Method of Disposition  1 ☑ Burial 2 □ Cremation 3 □ Removal from 4 □ Donation 5 □ Other (Specify)   | State 20b. Place ceme  | of Dispos          | ition (Name of<br>atory or other pi                  |   | ate 20                                       | c. Location - City  |  |
| Balt Balt           | permit. Pa<br>Departmen<br>Importent<br>eny injury   |                | 21. Signature of Funeral Service Licensee  |  | RO                 | Name and Add   | ess of Facility FUNERAL HO                      | 917 OME MART                                 | CEMETERY  | INGDON, PA<br>ROAD<br>WV 25401               |
|                     | Physician<br>/Medical<br>Examiner  |                |  | Or as a consequence  | e of):             | the mode of dy                                       | ing, such as cardiac or                         | respiratory arrest                           | dia   | Approximate Interval Between Onset and Death |
| 760,0               | te be executed<br>ysician and<br>e burial-transit  | cal Examiner   | cause. Enter Underlying Cause (Disease or injury that initiated events c.  | (or as a consequence   |                    |  |   |  |   |  |
| .O. Box 68          | The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit | Physician/Medi | in the past 12 months?   | come of pregnancy<br>irth 2 Fetal deat<br>ant at time of death<br>own  |                    | ctopic pregnand<br>Other (specify) _                 | у   |  | 23d. Date of di<br>Month                                    | elivery<br>Day Year                          |
| ecords, P           | iw requires that<br>s been signed b<br>should be det   | (a)            | Part II. Other significant conditions contributing to d  | eath but not resulting   | in the und         | erlying cause gr                                     | ven in Part I.                                  | 23e. Did tobac                               | 1   | to the cause of death?                       |
|                     | vicien: The law<br>certificate has b<br>rector, page 2 s   | e Completed    | 25. Was case referred to medical   | #  |                    |  |   | 24a. Was an autopsy performed                | ? prior to death?   |  |
| ō                   | Phys<br>this<br>aldi   | ToB            | examiner?  1  Yes  No  Hospital: 1  1  27. Manner of Death   | 26. Place of Death ( Pl |                    |  | ecify)  |  |   |  |
| 2                   | lo the hospitel or Attending within 24 hours after death.  To the Funerel Director: After completely filled in by the funer  |                | 29a. Certifier Certifying Physician: To the  | of Injury - At home, fing, etc. (Specify)  | o doeth -          |  |   | City or Town, St                             | fate)   | ural Route Number,                           |
|                     | vithin 24 P  | Medical        | 29a. Certifier (Check only one) Certifying Physician: To the bound one) Certifying Physician: To the bound one) Certifying Physician: To the bound one) Certifying Physician: To the certification Physician: To the certification Phy | isis of examination are stated.  | nd/or inves        | 29c. Licens  | p   | at the time, date                            | e(s) and manner a<br>and place, and du<br>Date signed (Moni | e to the cause(s)                            |
|                     | 5  | - 12           | 10. Name and address of person who cooplesed caus  | o of death (Item 23a)  | (Туре, Ргі         | (Int)  | 6806  | De   | Tanker  | 14,2005                                      |
|                     | s Sta  | e<br>ir        | B1. Date filed (Month, Dat), Year) DEC 2 8 2005  | NOTTC  | Took Y             | Total  | tagenta   | us, n  | D 21  | 1742   |

|            |   |   | For<br>State<br>Registrar   | State of M   | laryland                               | •                    |                                     | t of H             | ealth a                               |                        |   | jiene                     | 05                                      | 41973   |   |
|------------|---|---|---|--|--|----------------------|-------------------------------------|--------------------|---------------------------------------|------------------------|---|---------------------------|---|---|---|
|            | Physici   | an  | 1. Decedent's Name (First, Middle, L  |  |  |                      |                                     |                    |                                       |                        | 2. Date of Dea<br>Month                     | Day                       | Year                                    | 3. Time of Death                                |   |
|            | /Medi<br>Examir   |   | 4a. Facility Name (If not institution, g  |  | 464                                    | -B-45                |                                     | Town, or           | Location                              | of Death               | 16  | 4c. C                     | ounty of Deat                           | h :   | _ |
|            | LAdiiii   | eı  | Garriett Gunt   | y Memou  |  | SAITZ                | R                                   | 0                  | akl                                   | ana                    | 人   |                           | avve                                    | H   |   |
|            | Funeral<br>Director   |   | 216-80-4529   | Sex 7. A<br>1 ☐ M 2 ☐ F  | ge (In yrs. last<br>91                 | t birthday)<br>Yrs.  | If Under<br>Months                  | 1 Year<br>Days     | If Under<br>Hours                     | 24 Hrs.<br>Min.        | 8. Date of Birth<br>(Month, De)<br>09/22/19 |                           |   | hplace (State or Foreign<br>buntry)<br>yland    |   |
|            | land<br>w   |   | Usual Residence of Decedent  10a. State 10b. County                                     |  | 10c. City, T                           | Town or Lo           | cation                              |                    |                                       |                        |   |                           |   | 10d. Inside City Limits                         | - |
|            | the Marylar<br>28a-f show<br>notified at  | tor   | MD Allega   | ny   |  | Cumbe                | erland                              |                    |                                       |                        |   |                           |   | 1 ☐Yes 2 ☐ No                                   |   |
|            | or 28s  | Jirec   | 10e. Street and Number  |  |  |                      | 10f. Zip                            | Code               |                                       |                        |   | 10g. Citize               | n of What Co                            | untry?  |   |
|            | ath wi  | ral   | 130 Columbia Stre   |  |  |                      |                                     | 2150               |                                       |                        |   | US                        |   |   |   |
| 21215-0036 | s 1 and 2 should be filed within 72 hours after death with the Maryland<br>I Health and Mental Hygiene.<br>Item 27 is marked other than "natural", or items 23a or 28a-f show<br>other traumatic event, It a Marical Examinar must be notified at | by Funeral Director   | 11. Marital Status  1 □ Never Married 2 □ Married  3 ☒ Widowed 4 □ Divorced             | 12. Was Deceden Armed Forces 1   | ?<br>[No                               |                      | Was Deced<br>f Yes, spec<br>1 ☐ Yes |                    | ispanic Ori<br>n, Mexicar<br>Specify: | gin? (Spe<br>i, Puerto | ecify Yes or No-<br>Rican, etc.)            |                           | . Race - Ame<br>Black, White<br>pecify: |   |   |
| 5-0        | 72 hours<br>"natural",  | eted  | 15. Decedent's (Specify only highest of   | Education<br>grade completed)  | 1                                      | 6a. Deced            | dent's Usua<br>kind of wo           | al Occupa          | ation<br>furing mos                   | t of worki             | ing   | 16b. Kind                 | of Business/                            | Industry  | _ |
| 121        | within<br>ene.<br>than *  | Completed   | Elementary/Secondary (0-12)   | College (1-4or   | 5+)                                    |                      |                                     | se retired         | )                                     |                        |   | TT                        |   |   |   |
| <b>d</b> 2 | filed Hygie<br>Hygie<br>other<br>ent, II  |   | 17. Father's Name (First, Middle, La  | st)  |  | Homem                | aker                                | -                  | 18. Mothe                             | r's Name               | (First, Middle,                             | Home<br>Maiden Su         | ımamə)                                  |   | _ |
| Maryland   | should be filed within of Mental Hygiene. marked other than imatic event, Ize M.  | То Ве   | William   | Andrew   | Sti                                    | itcher               |                                     |                    | Marg                                  | aret                   |   | A11e                      | en                                      | Grooms  |   |
| lary       | 2 shorand Name is ma  | -   | 19a. Informant's Name/Relationship  |  |  |                      | 3                                   |                    |                                       |                        | I Route Numbe                               |                           |   | (ip Code)                                       |   |
|            | permit. Pages 1 and 2<br>Department of Health a<br>Important: If Item 27 is<br>any injury or other tra<br><u>once</u> .   |   | Rita Grimm / Daugh: 20a. Method of Disposition  | ter  |  |                      | Stree:<br>sition (Nan               |                    | untain                                |                        | Park, Ma                                    | ,                         |   |   |   |
| Baltimore, | nt of h   |   | 1 Burial 2 ☐ Cremation 3  |  | cemi                                   | etery, crer          | matory or o                         | ther place         |                                       | 2/08/                  |   |                           | tion - City or                          |   |   |
| Ħ          | artme<br>artme<br>ortant<br>injury  |   | * 4 ☐ Donation 5 ☐ Other (Special Signature of Funeral Service Light                    |  | Julise                                 |                      |                                     |                    |                                       |                        | ms Family                                   |                           | rland, M<br>ral Home                    | ,   |   |
| Ba         | Depa<br>Impo<br>any ir  |   | 1 Labort (  | -aclas   | ue/                                    |                      |                                     |                    |                                       |                        | mberland,                                   |                           |   | ,   | 1 |
| 8760,      | Medical Examiner and buysician and buysician and strength strength from the purish transit  | Medical resulting in death)  The sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury)  The sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury) |   |  |  |                      |                                     |                    |                                       |                        | Q I   | ne                        | ned                                     | Onset and Death                                 |   |
| .O. Box 6  | law requires that the death certificate be execut as been signed by the attending physician and 2 should be detached for use as the burial-trad   | Physician/Med   | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown | 23c. If yes, outcom<br>1 ☐ Live birth<br>4 ☐ Pregnant a<br>9 ☐ Unknown | 2 ☐ Fetal de                           | ath 3                | Ectopic pro                         |                    |                                       |                        | <u> </u>                                    | 230                       | d. Date of deli<br>Month                | very<br>Day Year                                |   |
| ecords, P  | w requires that<br>been signed b<br>should be deta  | ρ   | Part II. Other significant conditions   | contributing to death  | out not resultin                       | ng in the ur         | nderlying ca                        | ause give          | on in Part I.                         |                        | 1   | bacco use                 | _                                       | the cause of death?                             |   |
| $\alpha$   | The ate his page  | Completed   |   |  |  |                      |                                     |                    |                                       |                        | 24a. Was a autops perfor                    | V                         | 24b. Were autoprior to death?           | topsy findings available completion of cause of |   |
| Vital      | Phyaician: Th<br>r this certificate<br>rai director, pag  | Be  | 25. Was case referred to medical examiner?  | Hospital:  |  |                      |                                     | Othe               | · 62                                  |                        | (Check only or                              |                           |   |   | - |
| o          | Phys<br>er this<br>eral di  | n: To   | 1 Yes 2 16  | 28a. Date of Inj<br>(Month, D  |  | Outpatien b. Time of |                                     | 8c. Injury<br>Work | 4 LI NU                               |                        | ne 5 🗆 Reside<br>28d. Describe he           |                           |   | ify)  | - |
| ö          | Attending F r death, ector; After by the funer  | atio  | 1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investigat   |  | ay Year)                               | Injury               | М                                   |                    | :?<br>/es 2 □!                        | No                     |   |                           |   |   |   |
| Division   |   | Certification:  | 3 ☐ Suicide 6 ☐ Could not<br>4 ☐ Homicide determine                                     | a 286. Place of Ir   | jury - At home<br>tc. <i>(Specify)</i> | , farm, str          | eet, factory                        | , office           |                                       | 2                      | 28f. Location (S<br>City or Town            | reet and A<br>n, State)   | lumber or Ru                            | ral Route Number,                               | 1 |
| ۵          | pital o   |   | 29a. Certifier Certifying   | Physician T. M. L.   | -f lenevile                            | -                    |                                     | -1.45              |                                       | 1.1                    |   |                           |   |   | - |
|            | To the Hospital or within 24 hours after To the Funeral Dir completely filled in I  | Medical   | (Check only one) 2 Medical Ex   | Physician: To the besi<br>aminer: On the basis<br>and manner s         | of examination                         | and/or inv           | estigation,                         | in my op           | e, date and                           | h occurre              | and due to the c<br>ed at the time, d       | ause(s) an<br>ate and pla | ace, and due                            | stated.<br>to the cause(s)                      |   |
|            | To th<br>withir<br>To th<br>comp  | Me  | 29b. Signature and title of certifier   |  | -                                      |                      | 29c                                 | . License          | number                                |                        | 2   | 9d. Date s                | igned (Month                            | , Dey, Year)                                    | - |
| )          | 3   |   | Paul Da   | nt mills   | 2/19                                   | 9                    |                                     | ナン                 | 615                                   | 4                      |   | 121                       | 07                                      | 05  |   |
|            | nes   | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Paul Davie Miller Do 69 Wolf Acres Dr Oakland MD 213   |   |  |  |                      |                                     |                    |                                       |                        |   |                           | SIZ CIM S                               | 3   |   |
|            | Sta<br>Registi  |   | 31. Date filed (Month, Day, Year) DEC 0 8 2   | Date filed (Month, Day, Year) 32. Hegistrar's Signature                |  |                      |                                     |                    |                                       |                        |   |                           |   |   | 3 |

|                     |  |                  | For   | State of M                              | aryland / Dep                                   |  |  | -                                | _                               | ible.                   |                                     |
|---------------------|--|------------------|---|---|---|--|--|----------------------------------|---------------------------------|-------------------------|-------------------------------------|
|                     |  |                  | 1 - State<br>Registrar  |   |   | rtificate of   |  | •                                | Reg. No. 0                      | 05                      | 41976                               |
| I                   | Physici  | an               | Decedent's Name (First, Middle, La  |   |   |  |  | 2. Date of De<br>Month           | Day                             | Year                    | 3. Time of Death                    |
|                     | /Medi  | cal              | SUDRADJAT  <br>4a. Facility Name (If not institution, give  |   |   |  | or Location of Death                                 | Dec.                             |                                 | 2005<br>by of Death     | 00:03AM                             |
|                     | Examir   |                  | HOWARD COUNT  |   |   |  | LUM1877  | (                                |                                 | WAF                     | 20                                  |
|                     | Funeral  |                  | 5. Social Security Number 6. S  |   | ge (In yrs. last birthday                       |  | If Under 24 Hrs.<br>Hours Min.                       | 8. Date of Bird<br>(Month, Da    | th<br>y, Year)                  | 9. Birthpl              | lace (State or Foreign              |
|                     | Director   |                  | 577-64-0984 Usual Residence of Decedent   | . W. W. 2.                              | 73 <sup>Yrs.</sup>                              |  |  | May 1,                           |                                 | Indon                   |                                     |
|                     | 72 hours after death with the Maryland<br>natural', or items 23a or 28a-1 show<br>diest Examinat must be nodified at                                 |                  | 10a. State 10b. County  |   | 10c. City, Town or L                            | ocation  |  |                                  |                                 | 10                      | Od. Inside City Limits              |
|                     | 8a-1 s   | ctor             | Maryland Montgo   | mery                                    | Silv  | er Spring  | <u></u>  |                                  |                                 |                         | 1 ☐ Yes 2 ☑ No                      |
|                     | with the a or 2  | Funeral Director | 10e. Street and Number  |   |   | 10f. Zip Code  |  |                                  | 10g. Citizen of                 |                         | i.                                  |
|                     | ter death  | nera             | 1821 Billman Lane   | 12. Was Decedent                        | Ever in U.S. 13.                                |  | 1902<br>Hispanic Origin? (Sp<br>pan, Mexican, Puerto | ecify Yes or No                  | - 14. Ra                        | Indon                   | an Indian,                          |
| 9                   | or ite   | Fur              | 1 ☐ Never Married 2 Married   | Armed Forces? 1 ☐ Yes 2 🔯 If Yes, Give  | No No   | If Yes, specify Cut  1 ☐ Yes 2 ☑ No                            |  | Rican, etc.)                     |                                 | ack, White, e           | <sub>etc.</sub><br>ic Islandeı      |
| 003                 | hours<br>tural',   | d by             | 3 Widowed 4 Divorced  | Year or Dates:                          | 10- 0   |  |  |                                  |                                 |                         |                                     |
| Maryland 21215-0036 | C 3  | Completed        | 15. Decedent's E<br>(Specify only highest grants)  Elementary/Secondary (0-12)                              | ade completed)                          | (Give   | edent's Usual Occu<br>e kind of work done<br>DO NOT use retire | pation<br>during most of worked)                     | ring                             | 16b. Kind of E                  | lusiness/Ind            | lustry                              |
| 212                 | filed within<br>Hygiene<br>other than "  | Com              | Elementary/Secondary (0-12)   | College (1-4or:                         |   | r/Securit  | у  |                                  | Indones                         | ian E                   | mbassv                              |
| nd                  | 8 E B 8  | Be               | 17. Father's Name (First, Middle, Last  | )                                       |   |  | 18. Mother's Nam                                     |                                  | Maiden Sumai                    | me)                     |                                     |
| ryla                | should<br>ind Men<br>a marke<br>umatic   | 2                | Dachlan Mustan  19a. Informant's Name/Relationship (  | narhadi                                 | 10h Mail  | ina Addraga (Strag   | Paima U  |                                  | C't T                           |                         | 0-10                                |
|                     | les 1 and 2 should to of Health and Ment I frem 27 la market rother traumatic  |                  | Ineke Mustamar  | ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, |   | Billman  |  |                                  |                                 |                         |                                     |
| ore,                | of Head  |                  | 20a. Method of Disposition  |   | 20b. Place of Disp                              | osition (Name of omatory or other pla                          | 1  | ver Spr<br>Date                  | 20c. Location                   | - City or Tov           | wn, State                           |
| ij                  | artment of I<br>ortant: If it<br>injury or o   |                  | 1 ☑ Burial 2 ☐ Cremation 3 ☐<br>'4 ☐ Donation 5 ☐ Other (Special  |   | Gate of   | Heaven<br>Cemeter  | ·  | 2,2005                           | Silver                          | Sprin                   | ie Mi                               |
| Baltimore,          | permit. Page<br>Department of<br>Important: If<br>any injury of<br>once.   |                  | 21. Signature of Funeral Service Like   | nsee /                                  | F <sub>1</sub>                                  | 2. Name and Addre  | Collins  |                                  |                                 |                         | 7,3                                 |
|                     | 40260  |                  | 23a. Part 1. Enter the disease, or com  | plications that cause                   | 0 50  | 00 Univer  | sity Blvd  | W. Si                            | 1.Spr.                          | Mary1                   | and 20001<br>Approximate            |
|                     |  |                  | Immediate Cause (Final  | one cause on each li                    | ine.  | itor the mode or dy  | ng, such as cardiac                                  | or respiratory ar                | 1651,                           |                         | Interval Between<br>Onset and Death |
|                     | Pnysician<br>/Medical  |                  | disease or condition resulting in death)  | aDue to (or as                          | consequence of):                                | ock  |  |                                  |                                 |                         | days                                |
| B                   | Examiner   |                  | Sequentially list conditions  | b                                       |   |  |  |                                  |                                 |                         | V                                   |
|                     | be ed  | Examiner         | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | Due to (or as                           | a consequence of):                              |  |  |                                  |                                 |                         |                                     |
| _6                  | sician and<br>burial-transit   | хап              | that initiated events<br>resulting in death) Last   | c<br>Due to (or as                      | a consequence of):                              |  |  |                                  |                                 |                         |                                     |
| 8760,               | law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit | calE             | (   | _ d                                     |   |  |  |                                  |                                 |                         |                                     |
| 9                   | ntificat<br>ng phy<br>ras th   |                  | IF FEMALE:  |   |   |  |  |                                  |                                 |                         |                                     |
| Вох                 | eath certific<br>attending pl  | lan/I            | 23b. Was decedent pregnant in the past 12 months?   |   | 2 Fetal death 3                                 | Ectopic pregnanc   | у  |                                  |                                 | ate of deliver          | ry<br>Day Year                      |
| P.O.                | that the de<br>ed by the a<br>detached t   | Physiclan/Med    | 1 ☐ Yes 2 ☐ No<br>9 ☐ Unknown   | 4□ Pregnant a<br>9□ Unknown             | t time of death 5 [                             | Other (specify) _  |  |                                  |                                 |                         | 24,                                 |
|                     | res that the signed by   | by Pr            | Part II. Other significant conditions   | contributing to death b                 | out not resulting in the u                      | ınderlying cause gı  | ven in Part I.                                       | 23e. Did to                      | bacco use con                   | tribute to the          | e cause of death?                   |
| ords                | v require<br>been sig<br>should b  |                  | Hente renal   | Jarlur                                  | e, and  | rsarce   | 2,   | 1 🗆 Y                            | ′es 2□No                        | 3 🗌 Proba               | ably 4 Unknown                      |
| Vital Records,      | e law r<br>has be<br>je 2 sh   | ompleted         | respiratory   | alure                                   | illen   | s, av  | euria,   | 24a. Was autop                   | sy                              | Were autopoprior to com | sy findings available               |
| al H                | Th<br>ate<br>pag   | O                | sick sinut  | Syndr                                   | one e   | rcepha   |  | 9                                | med?                            | death?                  | No                                  |
|                     |  | o Be             | 25. Was case referred to medical examiner?  1  Yes 2  | Hospital:                               | ent 2 ☐ ER/Outpatie                             | nt 3□ DOA Ott  | 26. Place of Deat                                    |                                  |                                 | <b>10</b> 11 1          |                                     |
| 1 of                | ding Phys<br>n.<br>After this<br>funeral di  | 1                | 27. Manner of Death   | 28a. Date of Inju<br>(Month, Da         | irv 28b. Time o                                 |  | 4 □ Nursing  | ane 5 □ Resid<br>28d. Describe h | lence 6 Oth<br>low injury occur |                         |                                     |
| sior                | Attending<br>r death.<br>ector: After<br>by the fune   | atlo             | 1 Natural 5 Pending 2 Accident investigatio 3 Suicide 6 Could not b   | n                                       | y / ou// Injury                                 |  | Yes 2 □ No   |                                  |                                 |                         |                                     |
| Division            | or Att   | Certification;   | 3 Suicide 6 Could not b   | 28e. Place of Inj                       | jury - At home, farm, st<br>c. <i>(Specify)</i> | reet, factory, office  |  | 28f. Location (S<br>City or Tow  | itreet and Numb<br>n, State)    | per or Rurai            | Route Number,                       |
| _                   | e Hospital or Atten<br>24 hours after deatl<br>Funeral Director:<br>etely filled in by the   | al Ce            | 29a. Certifier 1 Certifying Pt  | nysician: To the best                   | of my knowledge, deat                           | h occurred at the tr   | me, date and place.                                  | and due to the                   | cause(s) and ma                 | anner as sta            | ated.                               |
|                     | To the Hospital or Attending Phwithin 24 hours after death. To the Funeral Director: After th completely filled in by the funeral                    | edical           | (Check only 2 Medical Examone)  | niner: On the basis o<br>and manner st  | i <b>t exa</b> mination and/or in               | vestigation, in my   | ppinion, death occurr                                | ed at the time, o                | date and place,                 | and due to t            | the cause(s)                        |
|                     |  | Σ                | 29b. Signature and title of certifier   | ECCD                                    |   | 29c. Licens  |  | 3                                | 29d. Date signe                 | d (Month, D             | ay, Year)                           |
| ,                   | 3  |                  |   | 11-4                                    |   | <u> 13</u>   | 6845   |                                  | Jec. C                          | )8, -                   | 2005                                |
|                     |  |                  | 30. Name and address of person who  | completed cause of d                    | leath (Item 23a) (Type,                         | Print) (MAI-   | CHING  | MYEN                             | ), MI                           | ) <sub>1</sub> FC       | CP                                  |
|                     | Sta  | te               | 31. Date filed (Month Pay, Year)  | 37 Registr                              | ar's Signature                                  |  | ) 0(0  | 44                               |                                 |                         |                                     |
|                     | Registr  | ar               | DEC T S S   | JUD CUL                                 | J. D. A.  |  |  |                                  |                                 |                         |                                     |

|           |  |                | For State Registrar   | State of Ma  |                              | epartment<br>Certificate   |   | nd Mental H                                   | ygiene                                | 05                                  | 41975   |
|-----------|--|----------------|---|--|------------------------------|--|---|---|---------------------------------------|-------------------------------------|---|
| H         | Physicia   | n              | Decedent's Name (First, Middle, Inc.)      Decedent's Name (First, Middle, Inc.)      Decedent's Name (First, Middle, Inc.)      Decedent's Name (First, Middle, Inc.)      Decedent's Name (First, Middle, Inc.)      Decedent's Name (First, Middle, Inc.)      Decedent's Name (First, Middle, Inc.)      Decedent's Name (First, Middle, Inc.)      Decedent's Name (First, Middle, Inc.)      Decedent's Name (First, Middle, Inc.)      Decedent's Name (First, Middle, Inc.)      Decedent's Name (First, Middle, Inc.)      Decedent's Name (First, Middle, Inc.)      Decedent's Name (First, Middle, Inc.)      Decedent's Name (First, Middle, Inc.)      Decedent's Name (First, Middle, Inc.)      Decedent (First, Midd | •  |                              |  |   | 2. Date of I<br>Month                         | Death<br>Day                          | Year                                | 3. Time of Death                              |
|           | /Medica  |                | BRUCE EDWA: 4a. Facility Name (If not institution, s  |  | IT X                         | 4b. City. To   | own, or Location of I                       | DECEMI<br>Death                               |                                       | 005<br>ity of Death                 | 11:45 A M                                     |
|           | LXamin   | •              | FREDERICK MEMO  | ORIAL HOSPIT   | 'AL                          |  | ERICK                                       |   |                                       | EDERI                               |   |
|           | Funeral  |                |   | . Sex 7. Age   | (In yrs. last birth          | day) If Under 1  | Year   If Under 24                          |   |                                       |                                     | place (State or Foreign intry)                |
|           | Director   |                | 212-68-8802   | 13⊠M 2□F 4   | 48 Y                         | s.   | Days   Hours                                |   | 26, 1957                              |                                     | cyland_                                       |
|           | land<br>bw   |                | Usual Residence of Decedent  10a. State 10b. County   |  | 10c. City, Town              | or Location  |   |   |                                       |                                     | 10d. Inside City Limits                       |
|           | Mary<br>I eh   | to             | Maryland Freder   | ick  | Frede                        | rick   |   |   |                                       |                                     | 1 ☐ Yes 2 ☐ No                                |
|           | death with the Maryland<br>ms 23a or 28a-f show<br>rinust te mulfilled at  | Director       | 10e. Street and Number  |  |                              | 10f. Zip C   | ode   |   | 10g. Citizen of                       | f What Cou                          |   |
|           | 23a c  |                | 7612A Devilbis  | s Bridge Roa   | ad                           |  | 21701                                       |   | U.                                    | S.A.                                |   |
|           | tems<br>tems   | Funeral        | 11. Marital Status  | 12. Was Decedent Ev<br>Armed Forces?   |                              | 13. Was Deceder<br>If Yes, specify   | nt of Hispanic Origin<br>Cuban, Mexican, F  | n? (Specify Yes or t<br>Puerto Rican, etc.)   | 14. Ra<br>Bla                         | ace - Ameri<br>ack, White,          |   |
| 0000      | rs afte  | by Fi          | 1 ☐ Never Married 2 ☐ Married<br>3 ☐ Widowed 4 ☐ IDivorced  | 1 ☐ Yes 24 No<br>If Yes, Give<br>Year or Dates:                              |                              | 1 ☐ Yes 2🛣   |   |   | Speci                                 | ify:                                |   |
|           | within 72 hours after<br>ene.<br>then "naturel", or Ite  |                | 15. Decedent's  | Education  | 16a. C                       | ecedent's Usual (  | Occupation                                  |   | 16b. Kind of I                        | Whi                                 |   |
| <u> </u>  | hin 7.   | pe             | (Specify only highest (Specondary (0-12)  | grade completed)  College (1-4or 5+)   |                              | Give kind of work<br>ife. DO NOT use   | done during most o<br>retired)              | of working                                    |                                       |                                     | .ddoy   |
| 7         | or the   | Completed      | 12  |  | D                            | elivery  |   |   | Newsp                                 | aper                                |   |
| מום       | be fit<br>d oth  | Be (           | 17. Father's Name (First, Middle, La  |  |                              |  |   | s Name (First, Midd                           | le, Maiden Suma                       | ıme)                                |   |
| 2         | should<br>and Men<br>marke<br>umatic   | ၉              | Ellis E.  | Mullinix   |                              |  |   | ada Murra                                     | J                                     |                                     |   |
| 2         | d 2 sh<br>th and<br>7 is n<br>treun  |                | 19a. Informant's Name/Relationship Ellis E. Mullini   |  |                              |  |   | or Rural Route Num                            |                                       |                                     | •   |
| ก         | permit. Pages 1 and 2 should<br>Deportment of Health and Men<br>Importent: If Item 27 is marke<br>eny Injury or other treumatic<br>once.   | ĺ              | 20a. Method of Disposition  | x - rather   |                              | Disposition (Name<br>crematory or other  |   | ad, Mt. A                                     | Alry, Ma<br>20c. Location             |                                     |   |
| 2         | ages<br>ant of<br>it: If II  |                | 1 XBurial 2 ☐ Cremation 3<br>4 ☐ Doffation 5 ☐ Other (Spe   | Removal from State   |                              |  | I .   | ry 12/15/0                                    |                                       | ,                                   |   |
| Dalilling | orter  | ŀ              | 21. Signature of Funeral Servi  |  | TTOVIGE                      | 22. Name and   | Address of Facility                         |   |                                       |                                     |   |
| ŏ         | Depe<br>Impo<br>eny Ir   |                | Hovest L  | Wille  | inv                          | Moleswo  | rth-Willi                                   | lams P.A.<br>d - Damaso                       | Funera                                | 1 Hom                               | ne<br>20872                                   |
|           |  |                | 23a. Part1. Enter the disease, or co<br>shock, or heart failure. List on  | mplications that caused the  | ne death. Do no              |  |   |   |                                       | yrand                               | Approximate<br>Interval Between               |
| - 1       | Physician  | - 1            | Immediate Cause (Final disease or condition   | 2  | 2nter                        | Sto  | TIL   |   |                                       |                                     | Onset and Death                               |
|           | /Medical   |                | resulting in death)   | Due to (or as a  | n quence of                  | 1  |   | 7   | 7                                     |                                     |   |
|           | Examiner   |                | Sequentially list conditions,   | b. the   | 15-8/6                       |  | paren                                       | atu (   | 0                                     |                                     |   |
|           |  | ine.           | if any, leading to immediate cause. Enter Underlying Cause (Disease or injury   | Due to (or as a  | consequence of               | :  | /   |   |                                       |                                     |   |
| •         | xecut<br>al-trar   | Examin         | that initiated events resulting in death) Last  | c. Due to (or as a   | consequence of               | :  |   |   |                                       | _                                   |   |
| ,<br>o    | cate be executed obysician and the burial-transit  | dica           |   |  |                              |  |   |   |                                       |                                     |   |
| 0         | g phy<br>as the  | ed             |   |  |                              |  |   |   |                                       |                                     |   |
| 5         | w requires that the death certific been signed by the attending p should be detached for use as  | Physician/Me   | IF FEMALE:<br>23b. Was decedent pregnant  | 23c. If yes, outcome of 1□Live birth 2                                       |                              | 2∏Estado seas  |   |   | 23d. Da                               | ate of delive                       | ery   |
|           | ed for   | SICIE          | in the past 12 months?<br>1 ☐ Yes 2 ☐ No  | 4☐ Pregnant at tir   |                              | 3 ☐ Ectopic preg<br>5 ☐ Other (spec  |   |   | M                                     | lonth                               | Day Year                                      |
|           | d by the   | ב<br>ב         | 9 Unknown   |  |                              |  |   |   |                                       |                                     |   |
| ń         | signe<br>bed   | 2              | Part II. Other significant conditions   | contributing to death but  | not resulting in the         | ne underlying cau:   | se given in Part I.                         |   |                                       |                                     | he cause of death?                            |
| 5         | neen<br>shouk  | erec           | f care  | 10 / 01  | 0 - ( 0 -                    |  |   | -   '.  | ]Yes 2□No                             | 3[]#100                             | pably 4 Unknown                               |
| ב         | hes law  | Completed      |   |  |                              |  |   | — 24a. Wa                                     | s an 24b.<br>opsy<br>formed?          | Were auto<br>prior to col<br>death? | opsy findings available impletion of cause of |
| 6         | n: Tr  | 3              | 25. Was case referred to medical  |  |                              |  |   | 1 ☐ Yes                                       | 2 D NO                                |                                     | 2□ No   |
| 5         | /sicle<br>s cert<br>directe  | 0              | examiner?   | Hospital: Inpatient  | 2 ER/Outp                    | atient 3 DOA   | 0.4   | f Death (Check only<br>ing Home 5 ☐ Res       | _                                     |                                     |   |
| 5         | g Phy<br>er thi  |                | 27. Manner of Death   | 28a. Date of Injury<br>(Month, Day )   | 28b. Tim                     |  | Injury at Work?                             |   | how injury occur                      |                                     | <b>y</b> )                                    |
| 2         | ath.<br>or: Aft  | atio           | 1 ☐₩atural 5 ☐ Pending<br>2 ☐ Accident investigati  | on   | <i>(ear)</i> Inju            | M  | Work?<br>1 ☐ Yes 2 ☐ No                     |   |                                       |                                     |   |
| Ž         | r Atte   | Certification: | 3 ☐ Suicide 6 ☐ Could not<br>4 ☐ Homicide determine   |  | · At home, farm<br>(Specify) | , street, factory, o   | ffice                                       | 28f. Location<br>City or To                   | (Street and Numi                      | ber or Rura                         | al Route Number.                              |
| 2         | oltal o  |                |   | 1  |                              |  |   |   |                                       |                                     |   |
|           | To the Hospital or Attending Physicien: The law requires that the death certificate be executed within 24 hours efter death.  To the Funeral Director: After this certificate hes been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit | edical         | 29a. Certifier 1 ☐ Certifying F (Check only one) 2 ☐ Medical Ex   | Physician: To the best of a miner: On the basis of examiner and manner state | xamination and/o             | leath occurred at l<br>or investigation, in  | the time, date and p<br>my opinion, death o | place, and due to the<br>occurred at the time | e cause(s) and m<br>, date and place, | anner as st                         | tated.<br>the cause(s)                        |
|           | othin:   | Med            | 29b. Signature and title of conflier  | A A  | · ·                          |  | icense number                               | 100   | 29d. Date signe                       |                                     |   |
|           | r s r 0  |                | ) / /   | 1/1/   | IN                           |  | 17/75                                       | 44  | 12                                    | /10/                                | 0)  |
|           | 3  |                | 30. Name and ad person wh   | completed cause of dea   | th (Item 23a) (Ty            | pe, Print)   | -5  |   |                                       |                                     |   |
|           |  |                | W   | 1/1- /7  | WITH                         | m  | 1   |   |                                       |                                     |   |
|           | State  |                | 31. Date filed (Month, Day, Year)   | 32. Registrar's  | s Signature                  | Soul's   |   |   |                                       |                                     |   |
|           | Registra   |                | DEC 13  | 7002 A   | ، سمار مع                    | The state of the s |   |   |                                       |                                     |   |

|                |  |                  |   | eState of Maryland Den  |  |   | •   |   |
|----------------|--|------------------|---|---|--|---|---|---|
|                |  |                  | 1- For Amend #23a po  |   | ertificate of Death  | 1   | 2005 41977  |   |
| П              | Physici  | an               | Decedent's Name (First, Middle, Last)   |   |  | 2. Date of Death<br>Month                 | Day Year 3. Time of Death   |   |
|                | /Medic<br>Examin   | cal              | ESTHER D. MICE  4a. Facility Name (If not institution, give s   |   | 4b. City, Town, or Location of Death   | DEC. 8                                    | 2005 7:10 A N   | 1 |
|                | Examili  | lei              | COLLINGSWOOD I  |   | ROCKVILLE  |   | MONTGOMERY  |   |
|                | Funeral  |                  | 5. Social Security Number 6. Sex  | 7. Age (In yrs. last birthday                                     |  | 8. Date of Birth<br>(Month, Day, Ye       | 9. Birthplace (State or Foreign<br>Country)                         | m |
|                | Director   |                  | 100-01-4019   | 90 Yrs.   |  | OCT 2 1                                   | 915 NY  | _ |
|                | aryland<br>show  | _                | 10a. State 10b. County  | 10c. City, Town or L  |  |   | 10d. Inside City Limits   |   |
|                | the Ma   | ecto             | MD MONTGON  10e. Street and Number  | MERY BARNE  | ESVILLE  | 40-                                       | 1 Yes 2 No  |   |
|                | 3a or  | Funeral Director | 22411 OLD HUNI  | ORED RD.  | 10f. Zip Code 20838  | log.                                      | Citizen of What Country?  USA                                       |   |
|                | ems 2  | nera             |   |   | . Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto | pecify Yes or No-                         | 14. Race - American Indian,<br>Black, White, etc.                   |   |
| 36             | safter, or the   | by Fu            | 1 ☐ Never Married 2 ☐ Married 3 🕱 Widowed 4 ☐ Divorced  | 1 ☐ Yes 2 X No If Yes, Give Year or Dates:                        | 1 ☐ Yes 2 No Specify:  |   | Specify: WHITE  |   |
| 21215-0036     | within 72 hours after death with the Maryland<br>ene.<br>than "natural", or Items 23e or 28e-f show<br>he Medical Examiner must be notified at | ted t            | 15. Decedent's Educ   | cation 16a. Dece  | edent's Usual Occupation   | 166                                       | WILLE  D. Kind of Business/Industry                                 |   |
| 218            | ithin 7<br>96.<br>nan "n   | Completed        | (Specify only highest grade<br>Elementary/Secondary (0-12)  | College (1-4or 5+)  | e kind of work done during most of work<br>DO NOT use retired)                 | ring                                      |   |   |
|                | filed w<br>Hygier<br>other ti  |                  | 12<br>17. Father's Name (First, Middle, Last)   | SAI   |  | e (First, Middle, Maid                    | OVIE THEATER  |   |
| an             | Mental<br>Mental<br>arked o  | To Be            | GEORGE DUKE   |   | STAVRO   | OULA LOU                                  | KAKOS   |   |
| Maryland       | and<br>and<br>ls m   |                  | 19a. Informant's Name/Relationship (Typ.  | oe, Print) 19b. Mail  | ling Address (Street and Number or Rui   | al Route Number, Ci                       | ity or Town, State, Zip Code) 20838                                 |   |
|                | 1 and 3<br>Health<br>tem 27<br>other tr  |                  | STEPHANIE DUKE /  | / NIECE 224   | HI OLD HUNDRED   | RD., BAI                                  | RNESVILLE, MD: Location - City or Town, State                       |   |
| Baltimore,     | Pages<br>nent of<br>int: If it   |                  | 1 ☐ Burial 2 ☐ Cremation 3 ☐ Re  4 ☐ Donation 5 ☐ Other (Specify)   | emoval from State cemetery, cre                                   | ematory or other place)  | 11 2                                      | ROOKLYN, NY   |   |
| alti           | permit. Page<br>Department o<br>Importent: If<br>any injury or<br>once.  |                  | 21. Signature of Funeral Service License  | 99 2  | HILL CEM. 12/1 22. Name and Address of Facility                                | 2703                                      | KOOKHIN, NI   |   |
| <u> </u>       | 99 = 59  |                  | Tura a.   | HILTON  | HILTON FUNERAL<br>P.O. BOX 86, BA  | <u> RNESVIL</u>                           |   |   |
| П              |  |                  | 23a. Part1:/Enter/the disease, or complic<br>shock-or heart failure. List only on<br>Immediate Cause (Final                     | cations that caused the death. Do not en                          | nter the mode of dying, such as cardiac  | or respiratory arrest,                    | Approximate<br>Interval Between<br>Onset and Death                  |   |
|                | Physician /Medical   |                  | disease or condition resulting in death)  | Due to (or as a consequence of):                                  | Dimilue  |   |   | _ |
| Ľ              | Examiner   |                  | Securitally flat perulitions b  | A Cute Por  | ne Faul  | ··  |   |   |
|                | led<br>nsit  | Examiner         | Securitally flat conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events | Dula to (or as a consequence of):  Congestive Hear                | t Failure  |   |   |   |
| oʻ             | ate be executed<br>nysician and<br>he burial-transit   | Exar             | that initiated events c. resulting in death) Last   | Due to (or as a consequence of):                                  |  |   |   |   |
| 8760,          | ate be<br>hysicia<br>the bur   | licai            | d   |   |  |   |   |   |
| 89 X           | that the death certifica<br>ed by the attending ph<br>detached for use as th   | Physician/Med    | IF FEMALE:  | 3c. If yes, outcome of pregnancy                                  |  |   | 20d Date of delivery  |   |
| Box            | death<br>e atten<br>d for u  | ician            | 23b. Was decedent pregnant in the past 12 movins? 1 □ Yes 2 □ No  | 1 Live birth 2 Fetal death 3 € 4 Pregnant at time of death 5 €    | □Ectopic pregnancy □ Other (specify)   |   | 23d. Date of delivery  Month Day Year                               |   |
| P.O.           | at the<br>d by the   | Phys             | 9 □ Unknoẃn   | 9□ Unknown  |  |   |   |   |
|                | es<br>De pe  | by               | Part II. Other significant conditions con   | tributing to death but not resulting in the i                     | underlying cause given in Part I.  | 23e. Did tobaco                           | co use contribute to the cause of death?  2 No 3 Probably 4 Unknown | 1 |
| COL            | w requir<br>been s<br>should   | ietec            |   |   |  | 24a. Was an                               | 24b. Were autopsy findings available                                |   |
| Vital Records, | i <b>cien:</b> The lav<br>certificate has<br>rector, page 2  | Completed        |   |   |  | autopsy<br>performed<br>1 ☐ Yes 2 ☐       | prior to completion of cause of death?                              |   |
| /ita           | cien:<br>ertifica<br>ector, I  | Be               | 25. Was case referred to medical examiner?  | - the la  |  | h (Check only one)                        |   |   |
| of             | Phys<br>this<br>ral dii  | - L              | 1 Yes 2 No  | ospital: 1 Inpatient 2 ER/Outpatie                                |  | me 5 Residence                            | 6 ☐Other (Specify)  | _ |
| ion            | ttending F<br>death.<br>ctor: After<br>/ the funera  | atior            | 1 Natural 5 ☐ Pending investigation   | (Month, Day Year) Injury  | Work?<br>M 1 ☐ Yes 2 ☐ No  |   | nary occurred   |   |
| Division       | l or Atten<br>after deatl<br>Director:<br>i in by the  | Certification:   | 3 ☐ Suicide 6 ☐ Could not be determined   | 28e. Place of Injury - At home, farm, st building, etc. (Specify) | treet, factory, office   | 28f. Location (Street<br>City or Town, St | and Number or Rural Route Number,                                   | Ħ |
|                | spitel ours at serel Dilled i  |                  | 29a. Certifier 1 Certifying Phys  | ician; to the best of my knowledge, deat                          | th accurred at the time, date and place  | and due to the cause                      | o(a) and manner as stated   |   |
|                | To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the fune                      | edical           | (Check only 2 Medical Examination)  | er: On the basis of examination and/or in and manner stated.      | nvestigation, in my opinion, death occur                                       | red at the time, date                     | and place, and due to the cause(s)                                  |   |
|                | To t<br>To t   | Σ                | 29b. Signature and title of certifier   | / MM  | 29c. License number  |   | Date signed (Month, Day, Year)                                      |   |
| !              | 0.   |                  | 30. Name and address of person who co   | moleted cause of death (It 00-)                                   | D006243  | 2 12                                      | 18/05   |   |
|                | 10   |                  | SAYED FICAY   | 4A() 9715 Mc  | dis Carle Dr. A  | Pocknil                                   | Le MD 20850   |   |
|                | Sta  |                  | 31. Date filed (Month, Day, Year)  DEC 1 3 2  | 32. Rejistrar's Signature,  |  |   | 1   |   |
|                | Registr  | वा               | PITO I 9 C  | The same of   |  |   |   |   |

|                     |   |                  | 1 - For<br>State<br>Registrar   |  | Marylan  | _                                       | artmen<br>rtificate                     |                       |                           | ınd M                |   | 200                  | )5 L                             | 1978   |          |
|---------------------|---|------------------|---|--|--|---|---|-----------------------|---------------------------|----------------------|---|----------------------|----------------------------------|--|----------|
| н                   | Physic  |                  | Decedent's Name (First, Middle     ONCKEN OWEN)   |  |  |   |   |                       |                           |                      | 2. Date of Deat<br>Month<br>DECEMBE           |                      | Ž <sup>o</sup> ar<br>2005        | 3. Time of Death                             |          |
|                     | /Medi<br>Examir   |                  | 4a. Facility Name (If not institution, WILLIAM HILL   | give street and numb   | er)  |   |   | Town, or              | Location o                | f Death              | DECEMBE                                       |                      | unty of Death                    | 7:45PM<br>)T                                 |          |
|                     | Funeral<br>Director   |                  | 5. Social Security Number 577–22–2027 Usual Residence of Decedent   | 6. Sex 7.  | Age (In yrs.<br><b>90</b>  | last birthday)<br>Yrs.                  | If Under<br>Months                      | 1 Year<br>Days        | If Under 2<br>Hours       | Min.                 | 8. Date of Birth<br>Month, Day,<br>JUNE 3,    | 1915                 | 9. Birthpl                       | ace (State or Fore                           | ign<br>C |
|                     | yland<br>how  |                  | 10a. State 10b. County  |  | 10c. Cit   | y, Town or Lo                           | cation                                  |                       |                           |                      |   |                      | 10                               | d. Inside City Lim                           | its      |
|                     | Be-f s  | Funeral Director |   | <b>FALBOT</b>  |  | EAS                                     | TON                                     |                       |                           |                      |   |                      |                                  | Yes 2 1                                      | 10       |
|                     | with the  | Dire             | 10e. Street and Number 501 DUTCHMANS  | A NTE  |  |   | 10f. Zip                                |                       | 1.601                     |                      | 10  | g. Citizen           | of What Count                    | ry?  |          |
|                     | death<br>ms 23  | eral             | 11. Marital Status  | 12. Was Decede   | ent Ever in U.   | .S.   13. V                             | Was Deced                               |                       | 1601<br>Spanic Orig       | in? (Spe             | ecify Yes or No-<br>Rican, etc.)              | 14. F                | USA<br>Race - America            | n Indian                                     |          |
| Maryland 21215-0036 | permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "naturel', or items 23e or 28e-f show enty injury or other treumetic event, the Medical Examinar must be resulted at AnG. | þ                | 1 ☐ Never Married 2 ☐ Marri<br>3 █ <b>X</b> Widowed 4 ☐ Divorced  | Armed Force  1 Xes 2  If Yes, Give  Year or Date                     |  | 1                                       | fYes,spec<br>I□Yes 2                    | _                     | Specify:                  | Puerto               | Rican, etc.)                                  |                      | Black, White, e                  | tc.  |          |
| 5-0                 | "natu   | letec            | 15. Decedent'<br>(Specify only highes   |  |  | 16a. Deced                              | lent's Usua<br>kind of won<br>DO NOT us | Occupa<br>done di     | tion<br>uring most        | of worki             | ng 1  | 6b. Kind o           | f Business/Indi                  | ustry  |          |
| 72                  | iene.<br>r then   | Completed        | Elementary/Secondary (0-12) 12  | College (1-4   | or 5+)   |   | ANAGE                                   |                       |                           |                      |   | TNV                  | ESTMENT                          | rc   |          |
| bu                  | al Hyg<br>I other   | BeC              | 17. Father's Name (First, Middle, L   |  |  | FI                                      | MAGE                                    |                       | 18. Mother                | 's Name              | (First, Middle, M                             |                      |                                  |  |          |
| ylaı                | outd b<br>Ments<br>arked  | 70               | ONCKEN OWENS  |  |  |   |   |                       |                           |                      | P. KING                                       |                      |                                  |  |          |
| Mar                 | d 2 sh<br>th and<br>7 Is m<br>treum   |                  | 19a. Informant's Name/Relationsh  JANE RICHARDS/  |  | T.A.T.   |   |   |                       |                           |                      | l Route Number,                               |                      |                                  | Code)  |          |
| <u>6</u>            | Heall<br>Heall<br>Hem 2   |                  | 20a. Method of Disposition  |  | 20b. P   | lace of Dispos                          | sition (Nam                             | e of                  |                           |                      | BERLIN, 1                                     |                      | <b>811</b><br>on - City or Tow   | vn. State                                    | _        |
| ê                   | Pages<br>ent of<br>nt: If i   |                  | 1 Burial 2 Tremation  4 Donation 5 Other (Sp  | 3 □Removal from Sta<br>ecify)  |  | emetery, cren<br>SAPEAK                 |   |                       |                           | R 12                 | 2/13/2005                                     |                      |                                  |  |          |
| Baltimore,          | permit. Departn Importe eny inju  | 10               | 21. Signature of Funeral Service L  |  | F.S.P.   | 22                                      | Name and                                | Address               | of Facility               |                      | & NEWNAN                                      |                      |                                  |  |          |
|                     | Physician<br>/Medical<br>Examiner   |                  | 23a. Part1. Enter the disease, or of shock, or heart failure. List of the shock of | a Due to (or   | sed the death<br>n line.<br>Declar<br>as a consequ<br>as a consequ | n. Do not ente                          | er the mode                             | of dying              | , such as c               | ardiac o             | r respiratory arre                            | st,                  |                                  | Approximate Interval Between Onset and Death | >        |
| 68760,              | tificate be executed og physician and as the burial-transit   | ledical Examine  | if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last   | c  | as a consequ   |   |   |                       |                           |                      |   |                      |                                  |  |          |
| O. Box              | The law requires that the death certific<br>tite has been signed by the attending pl<br>page 2 should be detached for use as t  | Physician/Me     | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown   | 23c. If yes, outcor<br>1 ☐ Live birth<br>4 ☐ Pregnant<br>9 ☐ Unknowr | 2 ☐Fetal<br>at time of de  | death 3 🗌                               | Ectopic pre<br>Other (spe               |                       |                           |                      |   |                      | Date of delivery<br>Month D      | /<br>Pay Year                                |          |
| rds, P.             | w requires that<br>been signed by<br>should be deta   |                  | Part II. Other significant condition  | s contributing to death  | [/. [  | on the un                               | derlying car                            | use given             | in Part I.                |                      |   |                      |                                  | cause of death?                              | n        |
| l Records,          |   | Completed by     | Demente   | 7  | ·  |   |   |                       |                           |                      | 24a. Was an<br>autopsy<br>performe<br>1 Yes 2 | L                    | death?                           | sy findings available                        | е        |
| Vita                | Physicien:<br>r this certifica<br>ral director, p   | Be               | 25. Was case referred to medical examiner?  | Hospital:  |  |   |   |                       |                           |                      | (Check only one)                              |                      |                                  |  |          |
| 7                   | ttending Phys<br>death.<br>:tor: After this<br>the funeral dir  | tlon; To         | 1 Yes 2 No  27. Manner of Death 1 Datural 5 Pending 2 Accident investigation  | 1 Unpa<br>28a. Date of Ir<br>(Month, I                               |  | ER/Outpatient<br>28b. Time of<br>Injury |   | c. injury a<br>Work?  | Tours                     | 2                    | ne 5 🗆 Residen<br>8d. Describe how            |                      |                                  |  |          |
| Divisi              | irec<br>irec<br>irec  | Certification;   | 3 Suicide 6 Could no<br>4 Homicide determin   | ot be 28e. Place of  | Injury - At hor<br>etc. (Specify                                   | me, farm, stre                          | et, factory,                            |                       |                           |                      | 8f. Location (Stre<br>City or Town,           | et and Nur<br>State) | mber or Rural F                  | Route Number,                                | _        |
|                     | To the Hospitel of within 24 hours af To the Funerel D completely filled in   | edical           | one)  | Physician: To the be<br>xaminer: On the basis<br>and manner          | OI GAAIIIIII au  | vledge, death<br>ion and/or inve        | occurred at<br>estigation, i            | the time<br>n my opir | , date and<br>nion, death | place, ar<br>occurre | nd due to the cau<br>d at the time, date      | se(s) and r          | manner as states, and due to the | ed.<br>ne cause(s)                           |          |
|                     | with To Con   | Σ                | 29b. Signature and title of certifier  30. Name and address of person w  AMNUST A   | all "  | 0  |   | 29c.                                    | Dicense r             | S28                       | Y                    | 290   | . Date ofgr<br>2/12  | ned (Month, Da                   | ny, Year)                                    |          |
|                     | Sxl   |                  | 30. Name and address of person w  | ho completed cause o   | death (Item  | 23a) (Type, P                           | rinty                                   | for                   | , St                      | 0                    | aston   | mn                   | 260                              | /  |          |
|                     | Sta<br>Registr  | te               | 31. Date filed (Month, Day, Year) DEC 1 3 2903  | 32. Regis  | strar's Signati  | ure<br>A. A.                            | ,                                       |                       |                           |                      |   |                      |                                  |  |          |

|  |  | 1 State Registrar  | antl   | Ce   | rtificate  | of Death   |  |  | 2.00  | 5 4   | 1979  |
|--|--|--|--|--|--|--|--|--|---|---|---|
| Physici<br>/Medic<br>Examin  | al   | DONALD E. OLSEN     4a. Facility Name (If not institution, given the content of the content      | ve street and number)  |  | 4b. City, To   | own, or Location   | of Death                                 | 2. Date of Death<br>Month<br>DECEMBER  |   | Year<br>005<br>of Death   | 3. Time of Death 11:15Pl  |
| Funeral<br>Director  |  |  |  | (In yrs. last birthday,  |  | EASTON Year If Under Days Hours  | 24 Hrs.<br>Min.                          | 8. Date of Birth<br>Month, Day,<br>JAN 24  | TAL<br>930  | 9. Birthpla   | ace (State or Fore  |
| Ba-f show  | ctor   | Usual Residence of Decedent  | bot  | 10c. City, Town or L   |  |  |  |  |   | 10  | d. Inside City Lin  |
| us Hygiene.<br>do ther than "natural", or liems 23a or 28a-1 show<br>event, I've Medical Examiner naal be notified at                                | Funeral Director   | 10e. Street and Number  700 Port  11. Marital Status   | 12. Was Decedent E   | ver in U.S. 13.  | Was Deceder  | / ( C / )  | igin? (Spe                               | ocify Yes or No-   |   | - America   | n Indian,   |
| atural', or ite  | by   | 1 ☑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced  15. Decedent's E   | 1 XYes 2 No<br>If Yes, Give<br>Year or Dates:                                |  | 1 Yes 2  | 15   |  |  | Specify:  |   | ITE   |
| giene.<br>erthan "na<br>i the Medii  | Completed  | (Specify only highest gr. Elementary/Secondary (0-12) 12   | cade completed)  College (1-4or 5+   | (Give  | kind of work<br>DO NOT use   | done during mos  | it of workir                             | ng   | HEMICA  |   | ,   |
| Mental Hy<br>arked other<br>atic event   | To Be (  | 17. Father's Name (First, Middle, Last  HAROLD B. OLSE   | IN .   |  |  | (  | CLADY                                    | (First, Middle, Ma   | N   |   |   |
| Department of Health and Men<br>Important: If Item 27 Is marke<br>any injury or other traumatic<br>once.   |  | 19a. Informant's Name/Relationship ( HAROLD B. OLSEN,  20a. Method of Disposition  1 □ Burial 2 (②Cremation 3 □  1 □ Oonation 5 □ Other (Speci.  | JR./BROTHE   |  | COUNT<br>osition (Name<br>matory or other  | RY CLUB  | DR.,                                     |  | MD 216  | 601<br>City or Tow  | ın, State   |
| Departm<br>Importa<br>any inju<br>once.  |  | 21. Signature of Funeral Service Lice  | -  | 2:   | 2. Name and  | Address of Facili  | ty                                       | & NEWNAI   |   |   |   |
| nysician<br>/Medical<br>Examiner   | J.   | 23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)   | a. Mali q  | 9.   | 4.5  |  |  | h Lung   |   | 1   | Approximate nterval Between Onset and Death   |
| ohysician and<br>the burial-transit  | dicai Examiner   | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last   | c. Due to (or as a   | consequence of):   | Vanc   | nes, A   | l ver                                    | Lung   | y»  |   |   |
| y the attending physician and tched for use as the burial-transit  | icai   | d any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events   | c. Due to (or as a d. 23c. If yes, outcome o 1 Live birth 2 4 Pregnant at ti | consequence of):  f pregnancy Fetal death 35                                     | Ectopic preg   | nancy  | l) ver                                   | Lung   |   | of delivery   | /<br>/ay Year   |
| gned by the attending<br>be detached for use as  | by Physician/Medical                                       | If any, leading to minimidate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 yes 2 No   | 23c. If yes, outcome o  1 Live birth 2  4 Pregnant at ti 9 Unknown           | consequence of):  f pregnancy  Fetal death  5                                    | □Ectopic preg<br>□ Other (speci  | nancy<br>ify)  |  |  | 23d. Date<br>Mont   | th D  | cause of death  |
| ts been signed by the attending<br>2 should be detached for use as   | Completed by Physician/Medical                             | If any, leading to ministrate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  | 23c. If yes, outcome o  1 Live birth 2  4 Pregnant at ti 9 Unknown           | consequence of):  f pregnancy  Fetal death  5                                    | □Ectopic preg<br>□ Other (speci  | nancy<br>ify)<br>se given in Part I  |  | 23e. Did tobace  1  Yes  24a. Was an autopsy performed 1 Yes 2   | 23d. Date Mont  | bute to the  3 Probate autops for to compath?                               | cause of death  |
| ts been signed by the attending<br>2 should be detached for use as   | To Be Completed by Physician/Medical                       | If any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1   | 23c. If yes, outcome o 1   | consequence of):  f pregnancy Fetal death 3 me of death 5 mot resulting in the u | □Ectopic pregion of the control of   | nancy<br>ify)<br>se given in Part I  | of Death                                 | 23e. Did tobac  1  Yes  24a. Was an autopsy performed  | 23d. Date Mont  | bute to the  Probate  or autops or to compath?  Yes 2  r (Specify).         | cause of death oby 4 Unknow  ry findings availabletion of cause   |
| teror adam.<br>Director: After this certificate has been signed by the attending<br>in by the funeral director, page 2 should be detached for use as | Certification; To Be Completed by Physician/Medical        | If any, leading to immodiate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1   | 23c. If yes, outcome o 1   | consequence of):  consequence of):  f pregnancy                                  | DEctopic preg  | 26. Place Other: 4 \( \text{Nu} \) Injury at Work? 1 \( \text{Yes} \) 2 \( \text{Iffice} \)        | o of Death<br>rrsing Hom<br>2<br>No      | 23e. Did tobace  1  Yes  24a. Was an autopsy performer. 1  Yes 20  Check onl one ne 5  Residence. 8d. Describe how in the control of the cont | 23d. Date Mont 2 1 No 3 24b. W pr de 1 1 le 6 1 Other injury occurrent and Number late)     | bute to the  B Probater  ere autops  for to compath?  Yes 2  r (Specify)  d | cause of death' oly 4 Unknow of findings availabletion of cause No ASSISTE LIVING   |
| teror adam.<br>Director: After this certificate has been signed by the attending<br>in by the funeral director, page 2 should be detached for use as | edical Certification: To Be Completed by Physician/Medical | If any, leading to immodate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1  | 23c. If yes, outcome o 1   | consequence of):  f pregnancy  | Deet, factory, o   | 26. Place Other: 4 □ Nu Injury at Work? 1 □ Yes 2 □  ffice  the time, date an my opinion, dea      | of Death rrsing Hom 2                    | 23e. Did tobac  1 Yes  24a. Was an autopsy performer 1 Yes 2 Check onl one 16 5 Residence 18d. Describe how in the call of the calls and the calls and the calls and the calls are the calls and the calls are the calls and the calls are the c | 23d. Date Mont  2 No 3  24b. W pr de No 1 L  e 6 COther injury occurrent and Number intare) | bute to the  Greatops  ere autops ior to comp ath?  Yes 2  ( (Specify) d    | cause of death only 4 Unknows findings availabletion of cause No  |
| been signed by the attending<br>should be detached for use as  | edical Certification: To Be Completed by Physician/Medical | If any, leading to immodule cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1   Yes 2   No 9   Unknown  Part II. Other significant conditions of the con | 23c. If yes, outcome o 1   | consequence of):  f pregnancy  | Dectopic pregion of the control of t | nancy  fiy)  26. Place Other: 4 Nu Injury at Work? 1 Yes 2 ffice the time, date an my opinion, dea | o of Death<br>arsing Hom<br>2<br>No<br>2 | 23e. Did tobac  1 Yes  24a. Was an autopsy performed to the control one to the caus dat the time, date   | 23d. Date Mont  2 No 24b. W pr de 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1                     | bute to the  By Probater  Grant to compath?  Yes 2  Compath?  To r Rural F  | cause of death only 4 Unknown of the cause of death only 4 Unknown of the cause of |

|                            |   |                               | 1 - For<br>State<br>Registrar  | State of   | Marylan  |  | artment<br><i>tificate</i>    |                             |                    | and M                   | ental Hyg                                   | iene<br>•••005                                | 41980  |
|----------------------------|---|-------------------------------|--|--|--|--|-------------------------------|-----------------------------|--------------------|-------------------------|---|---|--|
|                            | Physic<br>/Medi   |                               | Decedent's Name (First, Middle, Last     MICHELE A. OLTM   |  |  |  |                               |                             |                    |                         | 2. Date of Dear<br>Month<br>Decembe         |   | 3. Time of Death  2:43am                           |
| 4                          | Exami   |                               | 4a. Facility Name (If not institution, give<br>Calvert Memorial  |  |  |  |                               | nce                         | Frede              | erick                   |   | 4c. County of I                               | Death  |
|                            | Funeral<br>Director   |                               | 5. Social Security Number 6. Se 292–40–3137 15  Usual Residence of Decedent  | м 2 <del>Д</del> F   | Age (In yrs. I   | ast birthday).<br>Yrs.                             | If Under 1<br>Months          | Year<br>Days                | If Under:<br>Hours | Min                     | 8. Date of Birth<br>(Month, Day,<br>Decembe | 9.<br>r 26,194                                | Birthplace (State or Foreign Country) 5 Ohio       |
|                            | permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "netural", or iteme 23a or 28a-f show early injury or other traumatic event, Ita Medical Exart at marked to notified at once. | al Director                   | 10a. State 10b. County MD Calvert  10e. Street and Number 28725 Burroughs  | Ct.  |  | , Town or Lo                                       | sville                        |                             |                    |                         |   | Og. Citizen of Wha<br>United S                | •  |
| 9600                       | hours after deatl<br>ural', or itsme 2  | Completed by Funeral Director | 11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced   | 12. Was Deced<br>Armed Forc<br>1 ☐ Yes 2<br>If Yes, Give<br>Year or Date | es?<br>• No  | 1  | ☐ Yes 2                       | No                          | Specify:           | gin? (Spe<br>, Puerto F | cify Yes or No-<br>Rican, etc.)             | 14. Race - /                                  | American Indian,<br>Vhite, etc.<br>White           |
| d 21215-0036               | 12 should be filed within 72 h and Mental Hygiene. 7 is marked other than "nat traumatic event, the Me High   |                               | 15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)  17. Father's Name (First, Middle, Last)   | cation<br>e completed)<br>College (1-4                                   | or 5+)   | 16a. Deced<br>(Give i<br>life. L<br>Homer          | kind of work<br>OO NOT use    | done du<br>retired)         | uring most         |                         | 9   | Own Home  Maiden Sumame)                      | ess/Industry                                       |
| Maryland                   | 2 should be<br>and Mental<br>is marked of<br>aumatic sv   | To Be                         | George Von Ruther 19a. Informant's Name/Relationship (Ty   | pe, Print)   |  | 19b. Mailin  | g Address (                   |                             | Ruth               | Rob                     | ards  | City or Town, Stat                            | te, Zip Code)                                      |
| Baltimore, N               | permit. Pages 1 and 1<br>Department of Health<br>Important: If Item 27<br>any injury or other tr<br>once.   |                               | Tammy Parsons/ D  20a. Method of Disposition  1  Burial 2  Cremation 3  4  Onation 5  Other (Specify)  |  | ce ce  | 28725<br>ace of Dispos<br>imetery, crem<br>itional | sition (Name<br>natory or oth | of<br>er place              | )                  | Di                      | ate   | ville,MD<br>20c. Location - City<br>Falls Chu | or Town, State                                     |
| Balt                       | permit. Pag<br>Department:<br>Important: I<br>sny injury o  |                               | 21. Signature of Funeral Service Lipenson  | Burgey   |  | 5  | 130 W                         | isco                        | nsin               | Ave                     | Sons,ING                                    | Shington                                      |  |
|                            | Physician<br>/Medical<br>Examiner   |                               | 23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, | Due to (or   | as a conseque  | ence of):  | Pesp                          | of dying,                   | , such as o        | cardiac or              | Failu.                                      | est,  | Approximate<br>Interval Between<br>Onset and Death |
| 8760,                      | cate be executed<br>physician and<br>the burial-transit   | dical Examiner                | any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  | Due to (or   | as a consequence of the same o | sis<br>ence of):                                   | 0                             |                             | <i>C</i> N         | 16.                     |   |   |  |
| P.O. Box 6                 | t the death certifi<br>by the attending<br>ached for use as   | Physician/Mec                 | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2  No 9 Unknown  |  | n 2 ☐ Fetal of<br>t at time of dea   | death 3 🔲  | Ectopic preg<br>Other (spec   | nancy<br>ify)               |                    |                         |   | 23d. Date of<br>Month                         | delivery<br>Day Year                               |
| ords, F                    | w requires that<br>been signed I<br>should be det   | by                            | Part II. Other significant conditions con  |  | h but not resul  | ting in the un                                     | derlying cau                  | se given                    | in Part I.         |                         |   | _   | e to the cause of death?    Probably 4 Dunknown    |
| ital Rec                   |   | se Completed                  | 25. Was case referred to medical   |  |  |  |                               |                             | 26 Place           | of Death                | 24a. Was an autopsy perform 1 Yes 2         | ed? prior death                               |  |
| Division of Vital Records, | l or Attending Physicien:<br>after death.<br>Director: After this certific<br>in by the funeral director,   | Certification: To B           | 27. Manner of Death  V Natural 5 □ Pending 2 □ Accident investigation 3 □ Suicide 6 □ Could not be   | -  |  | R/Outpatient<br>28b. Time of<br>Injury             | M 280                         | Other:<br>Unjury a<br>Work? | 4 🗆 Nur            | sing Hom<br>28          | e 5 🗆 Resider<br>3d. Describe how           | nce 6 □Other (S<br>w injury occurred          |  |
| Ö                          | To the Hospitel or At within 24 hours after of To the Funeral Direct completely filled in by  |                               | 4 Homicide determined  29a. Certifier Certifying Phys  | building,  | etc. (Specify)   | ledge death  | occurred at                   | the time                    | , date and         | nlace ar                | City or Town,                               | State)  | Rural Route Number,                                |
| )                          | To the Ho within 24 I To the Fu completely  | Medical                       | 29b. Signature and title of certifier  | er: On the basis and manner  | s or examination   | on and/or inve                                     | estigation, in                | imy opir                    | nion, death        | occurred                | d at the time, da                           | te and place, and c                           | onth, Day, Year)                                   |
|                            | Sta<br>Registra   | te                            | 30. Name and address of person who co  | mpleted cause o  | of death (Item 2   | 05P 1  | Q iD                          |                             | Poll               | 166                     | Frede                                       |   | 10 206)8   |

|                   |  |                     | 1 - For<br>State<br>Registrar  | State of Maryland   | / Depa                   |   | ealth and N  | Mental Hy                                 | _                                      | ie.  |
|-------------------|--|---------------------|--|---|--------------------------|---|--|---|--|--|
| I                 | Physic   |                     | 1. Decedent's Name (First, Middle, Las<br>Paul O'Nei   | •   |                          |   |  | 2. Date of Dea                            | Day Y                                  | 'ear 4'. 25 PM                                       |
|                   | /Medi<br>Exami   |                     | 4a. Facility Name (If not institution, give  |   |                          | 4b. City, Town, or  | Location of Death                                  | 119                                       | 4c. County of                          |  |
|                   |  |                     | Memorial H   | ospital   |                          | Cum   | ser la   |   |  | gary   |
|                   | Funeral<br>Director  |                     | 5. Social Security Number 6. Se 220-32-3868  | x 7. Age (In yrs. las<br>MM 2□ F 68   | t birthday)<br>Yrs.      | If Under 1 Year<br>Months Days  | Hours Min.   | 8. Date of Birtl<br>(Month, Day<br>Feb. 1 | v, Year)                               | Birthplace (State or Foreign<br>Country)<br>[aryland |
|                   | e Maryland<br>8a-f show<br>Illied at   | ctor                | MD. 10b. County Allegany   | 10c. City, 1<br>Wes   | fown or Lo               |   |  |   |  | 10d. Inside City Limits 1 ☐ Yes 2X No                |
|                   | uth with th<br>23a or 26<br>ust be no  | al Dire             | 10e. Street and Number<br>21317 Donna St   |   |                          | 10f. Zip Code<br>21562  | 2  |   | 10g. Citizen of Wh<br>United S         |  |
| 5-0036            | n 72 hours effer death with the Maryland<br>"naturel", or lieme 23e or 28e-f show<br>edical Exerciper must be notified at  | by Funeral Director | 11. Marital Status  1 Never Married **Married** 3 Widowed 4 Divorced   | 12. Was Decedent Ever in U.S. Armed Forces?  124 s 2 □ No 11 Yes, Give Vietnam Year or Dates:           | 13. Y                    | Was Decedent of His<br>f Yes, specify Cuban<br>1 ☐ Yes 2☐No                       | panic Origin? (Sp<br>, Mexican, Puerto<br>Specify: | ecify Yes or No-<br>Rican, etc.)          | 14. Race -<br>Black,<br>Specify:       | American Indian,<br>White, etc.<br>white             |
| 21215-0           | C * 34   | Completed           | 15. Decedent's Edi<br>(Specify only highest grad<br>Elementary/Secondary (0-12)  | cation (e completed) College (1-4or 5+)   | (Give<br>life. i         | dent's Usual Occupat<br>kind of work done du<br>DO NOT use retired)<br>rmy Office | ring most of work                                  | ing                                       | 16b. Kind of Busin                     | ness/Industry<br>tates Army                          |
| Maryland 2        | ges 1 and 2 should be filed within to filed within to file Hygiene. If item 27 is marked other than or other traumatic event, it.e. M.                             | To Be C             | 17. Father's Name (First, Middle, Last) Paul O'Nei   |   |                          |   | Ruth   | Dawson                                    |  |  |
|                   | 1 and 2 sho<br>Health and<br>em 27 la ma<br>ither trauma   |                     | 19a. Informant's Name/Relationship (T) Joyce O'Neil/ wife  |   | 2131                     | g Address (Street ar<br>7 Donna St  |  |   |  |  |
| Baltimore,        | Fire   |                     | 20a. Method of Disposition  ★★Burial 2 □ Cremation 3 □ F  ' 4 □ Donation 5 □ Other (Specify)   | Removal from State  | Vete:                    | sition (Name of<br>natory or other place)<br>rans Cemet                           | ery 200  | 12/<br>05                                 |  | y or Town, State<br>ne, Maryland                     |
| Ball              | permit. Departn Importa any inju   |                     | 21. Signature of Funeral Service Licens  J. Wilyne   | Sal   | 1                        | Name and Address Church   | St., Wes   | sternpor                                  | t. Marvla                              | and 21562  |
|                   | Prrysician<br>/Medical<br>Examiner   |                     | 23a. Part . Enter the disease, or compl<br>shock, or heart failure. List only of<br>Immediate Cause (Final<br>disease or condition<br>resulting in death)  | ications that caused the death. If the cause on each line.  Due to (or as a consequent)                 | Com                      | or the mode of dying,   | such as cardiac                                    | or respiratory arr                        | est,                                   | Approximate Interval Between Onset and Death Onum    |
| 8760,             | ate be executed hysician and the burial-transit  | dical Examiner      | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | Due to (or as a consequent Due to (or as a consequent Due to (or as a consequent                        |                          |   | pui  | wieny                                     | dizes                                  | 2  |
| P.O. Box 6        | Tha faw requires that the death certificate be executed the has been signed by the attending physician and bage 2 should ba detached for usa as the burial-transit | Physician/Med       | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown   | 3c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de: 4 ☐ Pregnant at time of death 9 ☐ Unknown | ath 3                    | Ectopic pregnancy<br>Other (specify)  |  |   | 23d. Date of<br>Month                  | f delivery<br>Day Year                               |
|                   | w requires that<br>been signed t<br>should ba deti   | by                  | Part II. Other significant conditions cor  | ntributing to death but not resultin  | g in the un              | derlying cause given  | in Part I.   |   |  | te to the cause of death?  Probably 4 □Unknown       |
| of Vital Records, |  | Completed           |  |   |                          |   |  | 24a. Was an autops perform                | y prior                                |  |
| <u>=</u>          | Phyalcian:<br>this certificanal director, I  | o Be                | 25. Was case referred to medical examiner?  1  Yes 2 No  | lospital: Inpatient 2 ER/   | Outpatient               | 045   | 6. Place of Death                                  |   |  |  |
| ion ol            | Attending Phys<br>r: death.<br>ector: After this<br>by the funeral di  | atlon: T            | 27. Manner of Death  |   | Time of Injury           | 28c. Injury a<br>Work?  |  |   | nce 6 Other (S<br>w injury occurred    | ъресіту)   |
| -                 | 1 to 1   | Certification:      | 3 Suicide 6 Could not be determined  | 28e. Place of Injury - At home, building, etc. (Specify)  | farm, stre               | et, factory, office   | 1  | 28f. Location (Str<br>City or Town        | reet and Number o                      | r Rural Route Number,                                |
|                   | the Hospital of the Loss and the Funeral Dipletely filled in   | edical              | one)   | sician: To the best of my knowled<br>ner: On the basis of examination<br>and manner stated.             | ige, death<br>and/or inv | occurred at the time, estigation, in my opin                                      | date and place, a<br>ion, death occurre            | and due to the ca<br>ed at the time, da   | use(s) and manne<br>ate and place, and | r as stated.<br>due to the cause(s)                  |
| )                 |  | 2                   | 29b. Signature and title of contifier  Aparthus  | d   |                          | 29c. License n<br>D6047   |  | 29  | 9d. Date signed (M                     |  |
|                   | 5NA  |                     | 30. Name an addr ss of person who co<br>Dr. Afaq Ahmad, Jo   |   |                          | •   | Cumber1  | and MD                                    | 21502                                  |  |
|                   | Sta<br>Registr   | _                   | 31. Date filed (Month, Day, Year)  | 32. Registrar's Signature   | 1                        | g og o  | Jumper 16  |   | 21302                                  |  |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** Theresa M. Pritt December 8, 2005 8:32 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Gilchrist Center- Hospice of Baltimore Baltimore Baltimore If Under 1 Year | If Under 24 Hrs.

Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) Feb. 2, 19 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 20€ F 212-14-5167 85 Director Washington, 3 Usual Residence of Decedent the Maryland 9 10a State 10b. County 10c. City, Town or Location worle 10d. Inside City Limits r than "natural", or items 23s or 28s-f ehov the Medical Examiner must be notified at 6 1 ☐ Yes 2K No Director Maryland Howard Ellicott City 3 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? with 5320 Dorsey Hall Drive, Apt. 104 21042 12. Was Decedent Ever in U.S. Amed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No If Yes, Give Specify: White 1 ☐ Yes 2X No Specify: à 3 Widowed 4 □ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 200 Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home ies 1 and 2 should be filed vol Health and Mental Hygie of Health and Mental Hygie If Item 27 is marked other to rother traumatic event, Lo 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ccember 81 Be Wade H. Barrett Beatrice Martina Osborne 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 10 and Linda P. Howard/ Daughter 1302 Walkabout Court, Eldersburg, MD 21784 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State December 13 1 XBurial 2 Cremation 3 Removal from State Gate of Heaven Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 2005 Silver Spring, Maryland 21. Signature of Funeral-Service Licensee Francis J. Collins Funeral Home Inc 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 500 University Blvd, W, Silver Spring, MD 20901 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ANURYSON **Physician** AURTIC yens /Medical Due to (or as a consequence of): Examiner Arminicione disco. to ears Sequentially has conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) burial-translt death certificate be execu Due to (or as a consequence of): Physician/Medical as the attending p IF FEMALE: 950 . If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 4☐Pregnant at time of death 5 Other (specify) ed by the a P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death? has 2□ No 1 Yes 2 No 1 Yes Be 25. Was case referred to medical examiner? 26. Place of Death [Check only one] Other: 4 Nursing Home 5 Residence 6 Other (Specify) Worp with 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) Certification: 28b. Time of 28d. Describe how injury occurred After 1 Natural 5 Pending investigation Injury death. 1 ☐ Yes 2 ☐ No 2 Accident Director 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospitel o within 24 hours aft To the Funerel Di Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D58303 2005 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ANDER CHARLES WI) 66(! IV CHARLES DWS:00 NO 2 1200 1. AARON

р

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

32 negistrar's Signature

Parties.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Amend Items 23a, per Dr Calling at 2 1 105 dhb

Reg. No. Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Month Year W PERETTI MARY 13 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death + YNCC FROSTBURG
If Under 1 Year If Under 24 Hrs. ALLEGAL 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday Birthplace (State or Foreign Country) **Funeral** Days Hours Months 1□M 2▼F Director 213-109732 Yrs. 11-10-191 Usual Residence of Decedent the Marylend 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28e-f show item 27 is marked other then "naturel", or items 23s or 28e-f show other treumstic svent. It a Modical Examinar must be notified at Yes 2 □ No Director WP PURBALLA FROSTBURG 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 33 WEST COLLEGE AVENUE 21532 U.S. death 1 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, permit. Pages 1 and 2 should be filed within 72 hours after or Department of Health and Mental Hygiene. Importent: If tiem 21 is marked other than "naturel; or fles any njury or other treumatic svent. It a Medical Examinations. Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: ģ 3 Widowed 4 Divorced WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) TEACHER SCHOOL 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be JOHN WILSON KATHLEEN HOBAN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) FRANCIS PERETTI / HUSBAND 33 W. COLLEGE AVENUE, FROSTBURG, MD 21532 20a. Method of Disposition
1 ABurial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State <sup>¹</sup> 4 □ Donation 5 □ Other (Specify) ST. MICHAEL CEMETERY | 12/17/05 FROSTBURG, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 60 W. MAIN STREET M00547 DOWEFS SOWERS FUNERAL HOME, P.A. Tlan FROSTBURG, MD 21532 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Fhysician Dehydrothin disease or condition resulting in death) 2 weeks /Medical Due to (or a a consequence of): Respiratory Failure 3 weeks Examiner Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine **Aspiration** Pneumonia 3 weeks use as the burial-transit certificate be executed aspera resulting in death) Last Due to (or as a consequence of). attending physician Box 68760 Stroke Physician/Medical IF FEMALE: 23c. if yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Year 4☐Pregnant at time of death Month Day 5 Other (specify) P.0. the 9 Unknown à Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. þ ypertension 1 Yes 2 No 3 Probably 4 Dunknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? has autopsy performed certificate I 2 No 1 Yes 1 ☐ Yes 2 ☐ No Hospitel or Attending Physicien: 25. Was case referred to medical Be 26. Place of Death Check onl one examiner? Other: 2 1 ☐ Yes 2 ☑ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 V Nursing Home 5 Residence 6 Other (Specify) this filled in by the funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred After 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No 2 Accident investigation 24 hours after death Funerel Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 2 To the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

5 State

Registrar DHMH 17 Rev 1/2001 32. Registrar's Signature

48 TARN TERRACE, FROSTBURG, MD 21532

30. Name and address of person who completed cause of death (item 23a) (Type, Print)

SANDHIR, M.D.,

7 2005

31. Date filed (Month, Day, Year)
DEC 2 7 20

DEC , 13,2005

|               |  | 1                | For<br>State<br>Registrar  | State                | of Maryla   |                       | artment<br>rtificate           |                   |               | ind M      |  | giene<br>Reg. 22.0    | 105                   | 41984  |
|---------------|--|------------------|--|----------------------|---|-----------------------|--------------------------------|-------------------|---------------|------------|--|-----------------------|-----------------------|--|
|               | Division   |                  | 1. Decedent's Name (First, Middle,   | Last)                |   |                       |                                |                   |               |            | 2. Date of De                          | ath<br>Day            | Year                  | 3. Time of Death                                       |
|               | Physicia<br>/Medic   |                  | Paul E.  | Ponton               | Sr.   |                       |                                |                   |               |            | Decemb                                 | er 9                  | 2005                  | 11:45 A M  |
| -             | Examin   | er               | 4a. Facility Name (If not institution,   | _                    |   |                       | 4b. City, To                   |                   |               | f Death    |  |                       | ounty of De           |  |
| 1914.5<br>181 |  |                  | Shady Grove Adv  5. Social Security Number   | entist<br>6. Sex     | 7. Age (In yrs.                                       |                       | If Under 1                     | kvi               | If Under 2    | 4 Hrs.     | 8 Date of Bir                          |                       | ntgom                 | ery irthplace (State or Foreign                        |
|               | Funeral Director   |                  | 578-20-7827  | 1 <b>X</b> M 2□ F    | 81  | Yrs.                  |                                | Days              | Hours         | Min.       | 8. Date of Bir<br>(Month, Da<br>Dec. 7 | , Year)<br>1924       |                       | shington DC  |
|               |  |                  | Usual Residence of Decedent  |                      | 1   |                       | L_                             |                   |               |            |  | ,                     |                       |  |
|               | how  |                  | 10a. State 10b. County   |                      | 10c. C  | ity, Town or Lo       | ocation                        |                   |               |            |  |                       |                       | 10d. Inside City Limits                                |
|               | Be-f e   | cto              |  | gomery               |   | Rockvi                |                                |                   |               |            |  |                       |                       | 1 ☐ Yes 2 🕅 No   |
|               | vith th  | Dire             | 10e. Street and Number<br>14729 Janice Di  |                      |   |                       | 10f. Zip C                     | ode<br>2085       | 2             |            |  |                       | n of What C           | ,  |
|               | s 23s  | Funeral Director |  |                      | ecedent Ever in U                                     | 15 13                 |                                |                   |               | in? (Spe   | crify Yes or No                        |                       | ed St                 | aces   |
|               | ter de   | Fun              | 11. Marital Status  1 ☐ Never Married 2 ☐ Marrie   | Armed I              | Forces?   |                       | If Yes, specify                | y Cubar           | n, Mexican    | Puerto     | Rican, etc.)                           |                       | Black, Wh             |  |
| 21215-0036    | within 72 hours after death with the Maryland<br>ene.<br>then "natural", or items 23s or 28s-f show<br>the Madical Examiner must be notified at  | þ                | 3X Widowed 4 □ Divorced  | If Yes, C<br>Year or | aive<br>Dates:  |                       | 1 ☐ Yes 2                      | X No              | Specify:      |            |  | S                     | pecity:               | White  |
| ည             | 72 ho  | Completed        | 15. Decedent's<br>(Specify only highest  |                      | d)  | (Give                 | dent's Usual                   | done di           | urina most    | of worki   | na                                     | 16b. Kind             | of Busines            | s/Industry   |
| 7             | ithin<br>nen   | du               | Elementary/Secondary (0·12)  | College              | (1-4or 5+)  | life.                 | DO NOT use                     | retired)          |               |            | 3                                      |                       |                       |  |
| C             | lied w<br>tygier<br>her ti   |                  | 17. Father's Name (First, Middle, L  | 4<br>act)            |   |                       | Civi1                          |                   |               |            | (First, Middle                         |                       | ineer                 | ing  |
| anc           | ntal Hed of  | Be C             | Roy C. Ponton  | 231/                 |   |                       |                                |                   |               |            | e Anit                                 |                       |                       |  |
| 2             | should<br>d Me<br>mark<br>matic  | 유                | 19a. Informant's Name/Relationshi  | io (Type, Print)     |   | 19b. Maili            | ng Address (                   | Street a          |               |            | I Route Numb                           |                       |                       | , Zip Code)  |
| Maryland      | permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Depertment of Health and Mental Hygiens. Important: If I tem 23a or 28e-1 ehow my injury or totally traumatic event, the Maulical Examinar must be notified at once.  |                  | Denise M. Sines  | J Daug               | hter  |                       |                                |                   |               |            |  |                       |                       | MD 21771   |
| Baltimore,    | E He H   |                  | 20a. Method of Disposition   |                      | 20b.  | Place of Dispo        | sition (Name                   | of of             |               |            | ate                                    |                       | -                     | or Town, State   |
| E             | Page 11 in State of the second |                  | 1 ☑Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp.  |                      | m State   | te of H               |                                |                   |               | essp       | ber 14                                 | Silve                 | er Sp                 | ring, MD   |
| alti          | Depertmen<br>Depertment:<br>mportant:<br>any injury  |                  | 21. Signature of Funeral Service L   | censes               |   | 22                    | 2. Name and                    | Address           | s of Facility |            |  |                       |                       | 10 East  |
| <u> </u>      | 89 E 2 9   |                  | 1 RACIA  | Hum                  | /   |                       |                                |                   |               | Gai        | thersb                                 | urg, l                | MD 208                | 877  |
|               | Physician<br>/Medical<br>Examiner  |                  | 23a. Part1. Enter the disease, or or shock, or heart failure. List of the final disease or condition resulting in death)   | a                    | o (or as a conse                                      | sis                   |                                |                   |               |            | MD N                                   |                       | `C                    | Approximate Interval Between Onset and Death One UKR   |
| 8760,         | cate be executed physicien and sthe buriel-transit   | dical Examiner   | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last   | b                    | o (or as a conse                                      | quence of):           |                                |                   |               |            |  |                       | J                     |  |
| P.O. Box 6    | death certiff<br>e attending<br>ed for use as  | Physician/Med    | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown  | 1 Live               | outcome of pregree birth 2 Fet gnant at time of known | taf death 3           | ∃Ectopic preg<br>∃ Other (spec |                   |               |            |  | 230                   | d. Date of d<br>Month | elivery<br>Day Year                                    |
| Records, F    | Se 150   | þ                | Part II. Other significant condition   | contributing to      | death but not re                                      | NCE /                 | inderlying cau                 | use give          | n in Part I.  |            |  | obacco use<br>Yes 2□1 |                       | to the cause of death?  Probably 4 □Unknown            |
| 000           | e law require<br>has been si<br>je 2 should t  | Completed        | RALIATION  | VAN                  | d Cl  | hem                   | OH                             | e iz              | AL            | DV         | 24a. Was                               |                       | 24b. Were             | autopsy findings available<br>o completion of cause of |
| ~             | 9 4 9  | mo;              |  |                      |   |                       |                                |                   |               |            | perfo                                  | ormed?                | death?                | ?  |
| /ita          | ysicien: Th<br>ils certificate<br>director, pag  | Be (             | 25. Was case referred to medical examiner?   |                      | _/_   |                       |                                |                   |               | of Death   | (Check only o                          | nne)                  |                       |  |
| of Vital      | \$ 5 E   | ၉                | 1 ☐ Yes 2 DNo  |                      | Impatient 2   |                       |                                |                   | 4 ( ) 14 ( )  |            | ne 5 🗆 Resi                            |                       |                       | pecify)  |
| n             | ing P  | on:              | 27. Manner of Death 1 DNataral 5 ☐ Pending   |                      | te of Injury<br>onth, Day Year)                       | 28b. Time o<br>Injury |                                | c. Injury<br>Work |               |            | 28d. Describe                          | how injury o          | ccurred               |  |
| Division      | Attending r death. ector: After by the fune  | Certification:   | 2 Accident investigation inves | ot be                | ce of Injury - At I                                   | home form et          | M                              |                   | 'es 2□N       |            | ORf Location /                         | Street and I          | Vumber or             | Rural Route Number,                                    |
| Ď             | after<br>Direction by  | ertif            | 4 Homicide determine   | bui                  | Iding, etc. (Spec                                     | city)                 | reet, ractory,                 | OIIICO            |               |            | City or To                             | wn, State)            | *B///DG/ G/ /         | Tara Tionio Tiamber,                                   |
| _             | To the Hospitel or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral   |                  | 29a. Certifier 1 ☐ Certifying  | Physician: To t      | pest of my kr   | nowledge, deat        | th occurred at                 | t the time        | e, date and   | d place,   | and due to the                         | cause(s) ar           | nd manner             | as stated.   |
|               | n 24  <br>n 24  <br>he Fu  | edical           | (Check only 2 Medical E  | xaminer; On the      | basis of examination                                  | nation and/or in      | ivestigation, in               | n my op           | inion, deat   | h occurr   | ed at the time,                        | date and pl           | ace, and du           | ue to the cause(s)                                     |
|               | To the To the Comp   | ž                | 29b. Signature and title of certifier  | XX                   | nen-  | M                     | 1 29c.                         | License           | number        | ^ 7        |  | 29d. Date s           | signed (Moi           | nth, Day, Year)  |
|               | 10   |                  | " July   | 7/2                  | un  | 1-1-                  | 1) 6                           | ~ 0               | 2 (           | <i>y</i> 2 | -                                      | HECE                  | inh                   | ER 9,2805  |
|               |  |                  | BAIZRY J. LY   | to dempfeted ca      | WD. 1   | 10211                 | Print) - Fe                    | RN                | woo           | d          | 2d.                                    | BeH                   | hesd                  | Apaya  |
|               | Sta<br>Registr   |                  | 31. Date filed (Mohth, Day, Year)  DEC 12  | 2005                 | Registrar's Sign                                      | A A                   | artis                          |                   |               |            |  |                       |                       |  |

|                           |  |                  | 1 - For<br>State<br>Registrar  | State of N                           | Maryland / Dep                            | eartment of Health an ertificate of Death   | d Mental Hygi  | •  | 41985  |
|---------------------------|--|------------------|--|--------------------------------------|---|---|--|--|--|
| П                         | Physic   | ian              | 1. Decedent's Name (First, Midd  | le, Last)                            |   |   | 2. Date of Death                                     |  | 3. Time of Death                             |
|                           | /Medi  |                  | Hilda  | M.                                   |   | Powe11  |  | Day Year 10, 2005                                | 6:10 A                                       |
| }                         | Exami  | ner              | 4a. Facility Name (If not institution  |                                      | r)  | 4b. City, Town, or Location of D  |  | 4c. County of Deat                               |  |
| Н                         |  |                  | 123 W. Main S  |                                      |   | Thurmont  |  | Frederic   | k_   |
|                           | Funeral  |                  | 5. Social Security Number 215-20-8380  | 6. Sex 7. A<br>1 ☐ M 2 💢 F           | Age (In yrs. last birthday                |   | Ain. (Month, Day,                                    | Year) 9. Birth                                   | nplace (State or Foreig<br>untry)            |
|                           | Director   |                  | Usual Residence of Decedent  |                                      | 79 Tis.                                   |   | March 9,   | 1926 Mary  | yland  |
|                           | yland<br>10W   |                  | 10a. State 10b. County   |                                      | 10c. City, Town or L                      | ocation   |  |  | 10d. Inside City Limits                      |
|                           | a-fs   | cto              | Maryland Fred  | lerick                               | Thurmo                                    | nt  |  |  | 1 XYes 2 □ No                                |
|                           | th the   | Funeral Director | 10e. Street and Number   |                                      |   | 10f. Zip Code   | 10   | g. Citizen of What Co                            | untry?                                       |
|                           | 23a  | a                | 123 W. Mai   | n St.                                |   | 21788   |  | United Sta                                       | ites   |
|                           | er deg   | Inel             | 11. Marital Status   | 12. Was Deceden<br>Armed Forces      | t Ever in U.S. 13.                        | Was Decedent of Hispanic Origin's<br>If Yes, specify Cuban, Mexican, Po             | (Specify Yes or No-<br>uerto Rican, etc.)            | 14. Race - Amer<br>Black, White                  |  |
| 5                         | s afte   | by F             | 1 ☐ Never Married 2 ☐ Mar<br>3 🛣 Widowed 4 ☐ Divorced  | If Yes, Give                         | No  | 1 ☐ Yes 2 X No Specify:   | ,,   |  | hite   |
| 3                         | hour   | pa               |  | Year or Dates                        |   | dealle Herrel O   |  |  |  |
| 0                         | nin 72<br>n "na  | piet             | (Specify only highe  | st grade completed)                  | (Give                                     | dent's Usual Occupation<br>skind of work done during most of<br>DO NOT use retired) | working 1  | 6b. Kind of Business/I                           | ndustry                                      |
| 21215-0036                | filed within 72 hours after death with the Maryland<br>Hygiene.<br>ther than "natural", or Items 23s or 28s-f show<br>ont, the Medical Examiras must be multined at  | Completed        | Elementary/Secondary (0-12)  | College (1-4or                       | 3+)                                       | amstress  |  | Clothing C                                       | Omnany                                       |
| 2                         | be file<br>tal Hyg<br>d othe<br>event,   | BeC              | 17. Father's Name (First, Middle,  | Last)                                |   | 18. Mother's  | Name (First, Middle, M                               |  | ompany                                       |
| Maryland                  | should b<br>ind Menta<br>i markad<br>umatic e  | 10 E             | Clayton  | Jefferson                            | McAfee                                    | Hazel   | L E.   | Wolfe  |  |
| <u>a</u>                  | 2 should be filed within<br>and Mental Hygiene.<br>Is markad other than<br>aumatic event, the Ma   |                  | 19a. Informant's Name/Relations  |                                      |   | ng Address (Street and Number or  |  |  |  |
|                           | ges 1 and 2 should be filed within 72 hours after death with the Marylan it of Health and Mental Hygiene. If of Health and Mental Hygiene. If them 27 is marked other than "natural", or items 23e or 28e-f show of ther traumatic event, the Medical Examiner must be notified at |                  |  | 1 / Son                              |   | 4 Catoctin Furna  | ice Rd./ Th  | urmont, MD                                       | 21788  |
| 5                         | Pages 1<br>nent of H<br>int: If ite<br>iry or otl  |                  | 20a. Method of Disposition<br>1 X8urial 2 ☐ Cremation  | 3 □Removal from State                |   | matory or other place)  |  | Oc. Location - City or T                         |  |
|                           | nit. Parantmen<br>ortant:<br>injury<br>g.  |                  | `4 ☐ Donation 5 ☐ Other (S   | pecify)                              | Blue Rid                                  | ge Cemetery 12,   | /14/2005 T   | hurmont, M                                       | laryland                                     |
| baltimore,                | permit. Page Department of Important: If any injury or once.   |                  | 21. Signature of Funeral Service   | Licensee                             | 2:  | 2. Name and Address of Facility   | Stauffer Fu  | neral Home                                       | es, P.A.                                     |
|                           |  |                  | 23a Part Friends discours  | Bele                                 | een 1                                     | 04 E.Main St. /   | Thurmont,  | Maryland   | 21788  |
|                           | nysician<br>/Medical<br>Examiner   |                  | shock, or heart failure. List<br>Immediate Cause (Final<br>disease or condition<br>resulting in death) | a. AT                                | ine.                                      | c (And, o Vasc  | -  |  | Approximate Interval Between Onset and Death |
|                           |  | Examiner         | if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events    | b. Due to (or as                     | s a consequence of):                      | -   |  |  |  |
| ,                         | cate be executed oblysician and the burial-transit   | ledicai Ex       | resulting in death) Last   | Due to (or as                        | s a consequence of):                      |   |  |  |  |
|                           | n certific<br>anding p<br>use as t   | /Mec             | IF FEMALE:   | V                                    |   |   |  | 1  |  |
|                           | y the atte   | Physician/M      | 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown                           |                                      | 2 Fetal death 3                           | Ectopic pregnancy Other (specify)   |  | 23d. Date of deliv<br>Month                      | ery<br>Day Year                              |
|                           | igned to   | by P             | Part II, Other significant condition   |                                      | out not resulting in the u                | nderlying cause given in Part I.  | 23e. Did toba  | cco use contribute to t                          | he cause of death?                           |
|                           | w require<br>been sig<br>should b  | edt              | Dinberes   | Mellirus                             |   |   | _ 1 ☐ Yes  | 2 □ No 3 □ Prot                                  | oably 4 Unknown                              |
| Photology The learned and | aw requast been 2 should   | Completed        |  |                                      |   |   | 24a. Was an  | 24b. Were auto                                   | opsy findings available                      |
| 1                         | ate ha   | E O              |  |                                      |   |   | - autopsy<br>performe                                | prior to co<br>death?                            | impletion of cause of                        |
| 3                         | ysician: in<br>is certificate<br>director, pag   | Be C             | 25. Was case referred to medical examiner?   |                                      |   | 26. Place of C  | 1 ☐ Yes 2 ☐<br>eath (Check only one)                 | No 1 ☐ Yes                                       | 2 NO   |
|                           | d s  | 2                | 1 Yes 2 No   | Hospital: 1 Inpati                   | ent 2 ER/Outpatien                        | t 3 DOA Other: 4 Nursing  | Home 5 Residence                                     | ce 6 ☐Other (Specif                              | (v)  |
|                           | After thi  | on:              | 27. Manner of Death 1 ☑ Natural 5 ☐ Pendin   | 28a. Date of Inju<br>(Month, Da      | ury 28b. Time of Injury                   | 28c. Injury at<br>Work?   | 28d. Describe how                                    |  | ,  |
| 5                         | r death. cotor: After by the funer   | cati             | 2 Accident investig  | gation                               |   | M 1 ☐ Yes 2 ☐ No  |  |  |  |
| more Attending            | : Big #  | Certification:   | 4 Homicide determ  | ined 286. Place of In<br>building, e | jury - At home, farm, str<br>c. (Specify) |   | City or Town,  |  |  |
| he Hoor                   | within 24 hours and the Funaral I  | ledicai          | one)   | and manner st                        | n examination and/or inv                  | n occurred at the time, date and pla<br>vestigation, in my opinion, death oc        | ce, and due to the cause<br>curred at the time, date | se(s) and manner as s<br>a and place, and due to | tated.<br>o the cause(s)                     |
| F                         | To To The To The The The The The The The The The The   | Σ                | 29b. Signature and title of certifier  | 5/-                                  |   | 29c. License number   |  | . Date signed (Month,                            | , . ,  |
| •                         | Q  | 1                | 30. Name an laddress of person   | who completed cause of               | death (Item 23a) (Type,                   | D003515   | 2  | 12.13  |  |
|                           | U  |                  | J L / R 31. Date filed (Month, Day, Year)  | 1 NTZ MO                             | 100 S                                     | Print) CENTER ST  | Thurmost   | , mo 2   | 21788  |
|                           | Sta<br>Registr   |                  | NEC 1  | 2 2005                               | ens of the second                         | Snauli)   |  |  |  |

|                 |  |                | 1 - For<br>State<br>Registrar   | State of Maryla  |                            | artment of H<br>rtificate of I                                    |  | Mental H                            | ygiene<br>Reg. No. 0         | 05   | 11986   |  |
|-----------------|--|----------------|---|--|----------------------------|---|--|-------------------------------------|------------------------------|--|---|--|
|                 | Physic   |                | Decedent's Name (First, Middle, RUTH  | ELLEN  | RANI                       | DAZZO   |  | 2. Date of D<br>Month<br>DEC •      |                              | Year 2005  | 3. Time of Death                              |  |
| and the         | /Medi<br>Exami   |                | 4a. Facility Name (If not institution, g  | give street and number)  | IUINI                      | 4b. City, Town, or BERL   |  |                                     | 4c. Cou                      | inty of Death  |   |  |
| T. T.           | Funeral<br>Director  |                | 210-24-3272   | . Sex<br>1 □ M 2 🛣 F 7. Age (In yrs  | . last birthday)<br>3 Yrs. | If Under 1 Year<br>Months Days                                    | If Under 24 H<br>Hours M                     |                                     | irth<br>Day, Year)           | 9. Birth   | place (State or Foreign<br>intry)<br>SYLVANIA |  |
|                 | Maryland<br>a-f show   | tor            | Usual Residence of Decedent  10a. State  10b. County  DELAWARE SUSSE                                      |  | ity, Town or Lo            |   |  |                                     |                              |  | 10d. Inside City Limits 1 X Yes 2 □ No        |  |
|                 | ath with the<br>23a or 28a<br>uat be not   | ral Director   | 10e. Street and Number  22 POLLY BRANC  |  | <u> </u>                   | 10f. Zip Code   | 75   |                                     | 10g. Citizen                 |  | ntry?   |  |
| 980             | 72 hours after death with the Maryland<br>naturel; or Items 23e or 28e-f show<br>Jical Examinat must be rediffed at  | by Funeral     | 11. Marital Status 1 □ Never Married 2 X Married 3 □ Widowed 4 □ Divorced                                 | 12. Was Decedent Ever in L<br>Armed Forces?<br>1 Yes 22 No<br>If Yes, Give<br>Year or Dates: |                            | Was Decedent of Hi<br>If Yes, specify Cuba<br>↑ ☐ Yes 2 🛣 No      | spanic Origin?<br>n, Mexican, Pu<br>Specify: | (Specify Yes or Nerto Rican, etc.)  | E                            | Race - Americ<br>Black, White,<br>ecity:                   | can Indian,<br>etc.<br>HITE                   |  |
| 21215-0036      | iges 1 and 2 should be filed within 72 hours after death with the Marylan to f Health and Mental Hygiene. If frem 27 is marked other than "natural", or Items 23a or 28a-f show or other traumatic event, Ita Madical Examinar must be rediffed at | Completed      | 15. Decedent's<br>(Specify only highest of<br>Elementary/Secondary (0-12)                                 | Education<br>trade completed)  College (1-4or 5+)  | (Give                      | dent's Usual Occupa<br>kind of work done of<br>DO NOT use retired | during most of w<br>)                        | vorking                             |                              | f Business/In  |   |  |
|                 | uld be filed a<br>fental Hygie<br>rked other i   | To Be Co       | 12 17. Father's Name (First, Middle, La CARL  | BOYER  | IAX                        | COLLECTO  | 18. Mother's N                               | ame (First, Middle                  |                              |  |   |  |
| , Maryland      | 1 and 2 should<br>Health and Men<br>tem 27 Is marke  |                | 19a. Informant's Name/Relationship SAMUEL P. RANDAZ   | (Type, Print)<br>ZO/HUSBAND  | 22 P                       | ng Address (Street a  | ind Number or                                | Rural Route Numb                    | per, City or Tov             | wn, State, Zip   |   |  |
| altimore,       | 7 4 6 6  |                | 20a. Method of Disposition  1 □ Burial 2 ☒ Cremation 3  4 □ Donation 5 □ Other (Spec                      | □Removal from State CRE  | cemetery, crei<br>EMATORY  | sition (Name of<br>matory or other place<br>OF DELMA              | RVA 12                                       | Date 2/9/05                         |                              | AR, DE   | Dwn, State                                    |  |
| Ba              | permit. F<br>Departm<br>Importar<br>any inju   |                | 23a. Parti Enter the disease, or co shock, or heart failure. List on                                      | full   | HA                         | Name and Addres  STINGS FU  er the mode of dying                  | NERAL H                                      | OME, SEL                            | BYVILLI                      | E, DE.   | 19975   |  |
|                 | Physician<br>/Medical  |                | snock, or heart failure. List on<br>Immediate Cause (Final<br>disease or condition<br>resulting in death) | a. Due to (or as a consec  | 1515                       |   |  |                                     |                              |  | Interval Between<br>Onset and Death           |  |
| · ·             | Examiner   | Examiner       | Sequentially list conditions, in the cause. Enter Underlying Cause (Disease or injury                     | b. — Para to (or as a consec   | ivanes of):                |   |  |                                     |                              |  |   |  |
| 68760,          | icate be executed<br>physician and<br>s the burial-transit   | edicai Exar    | that initiated events resulting in death) Last  | C. Due to (or as a conseq  | quence of):                |   |  |                                     |                              |  |   |  |
| P.O. Box 68     | The law requires that the death certifica<br>Ite has been signed by the attending ph<br>bage 2 should be detached for use as the   | Physiclan/Med  | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown                   |  | Date of delive             | ery<br>Day Year   |  |                                     |                              |  |   |  |
|                 | equires that<br>en signed by<br>ould be deta   | þ              | Part II. Other significant conditions   | contributing to death but not res  | ulting in the ur           | nderlying cause give  | n in Part I.                                 |                                     | tobacco use co               | per-   | ne cause of death?                            |  |
| Vital Records,  |  | Completed      | 25. Was case referred to medical  |  |                            |   |  | 24a. Was<br>auto<br>perfo<br>1  Yes |                              | D. Were autop<br>prior to con<br>death?<br>1 \( \text{Yes} | psy findings available inpletion of cause of  |  |
| Division of Vit | ding Pl<br>h.<br>After tl<br>funera  | tlon: To Be    | ther (Specify   | ")   |                            |   |  |                                     |                              |  |   |  |
| DIVISI          | tal or Attensis after deatl  | Certification: | 2 Accident Investigation 3 Suicide 6 Could not determined   | be con Bland of Lainer Alle  | ome, farm, stre            |   | es 2 No                                      | 28f. Location (<br>City or Tol      | Street and Nun<br>wn, State) | nber or Rural  | I Route Number,                               |  |
|                 | To the Hospital or Al<br>within 24 hours after of<br>To the Funeral Direc<br>completely filled in by   | Medical        |   |  |                            |   |  |                                     |                              |  |   |  |
|                 | T WW.  | /              | 29b. Signature and title of certifier  30. Name and address of person who                                 | completed cause of death floor   | 23a) (Type 5               | 29c. License  | 4283   | 41000                               | 29d. Date sign               | ed (Month)   | Year)   |  |
|                 | Sta  | te             | 30. Name and address of person who Rober D  31. Date filed (Month, Day, Year)                             | 32. Registrar's Signa  |                            | Dury 6  | Drive  | Berl                                | L 1.                         | カロ   | 21811   |  |
|                 | Registr  | ar             | ULC 12  | 2005 Moline  | H. A                       | round B   |  |                                     |                              |  |   |  |

|                     |  |                      | 1 - State  | State of Mary                                 |   | artment of F   |                 | •   | 200               | F                                    | 1.1007   |
|---------------------|--|----------------------|--|---|---|--|-----------------|---|-------------------|--------------------------------------|--|
|                     |  |                      | Registrar  1. Decedent's Name (First, Middle, Las                              | et)   | Cei                                     | unicate of   | Deain           | 2. Date of De                                 | Regulad U         | J                                    | 3. Time of Death                                   |
| п                   | Physici  |                      |  | ames Ruarke                                   |   |  |                 | Month<br>Dec.                                 | Day               | Year<br>105                          | 7:42 PM  |
|                     | /Medic<br>Examir   |                      | 4a. Facility Name (If not institution, give                                    |   |   | 4b. City, Town, or   | r Location of   |   | 4c. County        |                                      | 7:42 FFI   |
| Н                   |  |                      | 30538 Black Duc  | k Lane  |   | Princes  | s Anne          | 2   |                   | rset                                 |  |
|                     | Funeral  |                      | Social Security Number     6. Security Number                                  |   | yrs. last birthday)                     | If Under 1 Year<br>Months Days   | If Under 2      | 4 Hrs. 8. Date of Bir<br>Min. (Month, Da      | th<br>V Year)     | 9. Birthp                            | place (State or Foreign                            |
|                     | Director   |                      | 214-70-5733  | 2 F 48  | 3 Yrs.                                  | INOTINIS Days  | Hours           |   | 1957              |                                      | aware  |
|                     | and w  |                      | Usual Residence of Decedent  10a. State 10b. County                            | 100   | c. City, Town or Lo                     | cation   |                 |   |                   |                                      | 10d. Inside City Limits                            |
|                     | Mary<br>f sho  | į                    | Maryland Somerse   | .+  | Princes                                 | a Anna   |                 |   |                   |                                      | 1 □ Yes 2 ☑ No                                     |
|                     | 1 the  | Director             | 10e. Street and Number   |   | rimces                                  | 10f. Zip Code  |                 |   | 10g. Citizen of   | What Cour                            | ntry?  |
|                     | 130 o  |                      | 30538 Black Duc  | k Lane  |   | 2185   | 3               |   | U.S.              |                                      |  |
|                     | deet   | ner                  | 11. Marital Status   | 12. Was Decedent Ever<br>Armed Forces?        | in U.S. 13.                             | Was Decedent of H  | ispanic Orig    | in? (Specify Yes or No<br>Puerto Rican, etc.) |                   | ce - Americ                          |  |
| 98                  | or Ite   | /Fu                  | 1 Never Married 2 Married  | 1 ☐ Yes 2 ☐ No                                |   |  | Specify:        | Puerto Rican, etc.)                           |                   | ck, White,                           | etc.   |
| 8                   | filed within 72 hours after deeth with the Maryland<br>Hygiene.<br>other than "naturel", or Items 23e or 28e-f show<br>ent, the Medical Examinar must be motified at   | Completed by Funeral | 3 Widowed 4 Vivorced   | Year or Dates:                                |   |  |                 |   | Specif            | Whit                                 |  |
| 15                  | n 72   | lete                 | 15. Decedent's Ed<br>(Specify only highest gra                                 | ucation<br>de completed)                      | (Give                                   | lent's Usual Occupa<br>kind of work done of<br>DO NOT use retired  | during most     | of working                                    | 16b. Kind of B    | usiness/Ind                          | dustry   |
| 12                  | within ene.  | т                    | Elementary/Secondary (0-12)  | College (1-4or 5+) none                       |   | chant Sea  | ,               |   | Morino            | Тиоп                                 | anoutation   |
| 2                   | Hygi<br>Other<br>ent, I  | Ö                    | 17. Father's Name (First, Middle, Last)  | none  | Her                                     | mane sea   |                 | 's Name (First, Middle,                       |                   |                                      | sportation   |
| Maryland 21215-0036 | permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Marylan Department of Health and Mentat Hygiene. Important; If item 27 is marked other than "naturel; or items 23e or 28e-f show any injury or other treumatic event, the Medical Examinating the notified at ODGe. | To Be                | Raymond Ruark  |   |   |  | Pa              | auline Mulo                                   | cahy              |                                      |  |
| ary                 | s ma   | Γ,                   | 19a. Informant's Name/Relationship (7  | •       | 19b. Mailin                             | g Address (Street a  | and Number      | or Rural Route Number                         | er, City or Town, | State, Zip                           | Code)  |
|                     | and 2<br>saith a<br>n 27 i   |                      | Robert Ruark, Br   | other   | 3900                                    | Doe Run  | Drive           | , Salisbury                                   | 7, Md. 2          | 1804                                 |  |
| altimore,           | of He<br>fiten   |                      | 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐                        |   | Ob. Place of Dispo<br>cemetery, cren    | sition (Name of<br>natory or other plac  | e)              | Date  | 20c. Location     | City or To                           | wn, State  |
| Ě                   | Pag<br>ment<br>ant; l  |                      | ' 4 □ Donation 5 □ Other (Specify  |   | Beechwood                               | d Cemeter  | y 1:            | 2/12/2005                                     | Princes           | s Ara                                | ne. Md.  |
| Ball                | Depart<br>Depart<br>Import<br>any in   |                      | 21. Signature of Funeral Service Licen.  | see   | 22                                      | . Name and Addres  | ss of Facility  | Hinman Fur                                    | neral Ho          | me                                   |  |
|                     | 0 □ = e ol   | 10 .1                | Jan 2 Kin  | MOO29   | 5 1                                     | 1673 Some  | rset A          | Ave, Prince                                   | ess Anne          | , Md.                                | . 21853  |
|                     |  |                      | 23a. Fart1. Enter the disease, or compositions, or heart failure. List only of | one cause on each line.                       | death. Do not ento                      | or the mode of dying   | g, such as c    | ardiac or respiratory a                       | rrest,            |                                      | Approximate<br>Interval Between<br>Onset and Death |
|                     | Physician  |                      | In hediate Cause (Final disease or condition resulting in death)               | a Had a                                       | e Ne                                    | ck Ca  | incer           |   |                   | 01                                   | e year   |
|                     | /Medical<br>Examiner   |                      | Tosuming in death)   | Due to (or as a cor                           | nsequence of):                          |  |                 |   |                   |                                      |  |
|                     |  | -                    | Sequentially list conditions,  |   |   |  |                 |   |                   |                                      |  |
|                     | uted<br>1<br>Insit   | Examiner             | if any, leading to immediate cause. Enter Underlying Cause (Disease or injury  | Dua to (or as a cor                           |   |  |                 |   |                   |                                      |  |
| Ć                   | exection and ial-tra   | Exa                  | that initiated events<br>resulting in death) Last                              | C. Due to (or as a cor                        | nsequence of):                          |  |                 |   |                   |                                      |  |
| 8760,               | icate be executed<br>physician and<br>s the burial-transit   | dicai                |  | d   |   |  |                 |   |                   |                                      |  |
| 9                   | ntifica<br>ng ph<br>as th  | Medi                 |  |   |   |  |                 |   |                   |                                      |  |
| Вох                 | that the death certifii<br>ed by the attending i<br>detached for use as  | Physician/Me         | 230. Was decedent pregnant   | 23c. If yes, outcome of pr<br>1☐Live birth 2☐ |   | Ectopic pregnancy  |                 |   |                   | te of delive                         | _  |
| о.<br>В             | e dea<br>the at  | sici                 | in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown                              | 4☐Pregnant at time<br>9☐ Unknown              |   | Other (specify)  |                 |   | Mo                | onth                                 | Day Year   |
| <u>а</u>            | d by   | Phy                  | Part II. Other significant conditions on                                       | merikusian en danek kus                       | A secondate of the state of             | 4-4-7  | B I             | on- Pide                                      |                   |                                      | 4 1 1 1 1  |
| ds,                 | 88 S 80  | by                   | rai, ii. Other significant conditions of                                       | intributing to death but no                   | r resulting in the dr                   | idenying cause give  | en in Part I.   | 238. Did to                                   | ,                 | ribute to the<br>3 ☐ Proba           | ably 4 Unknown                                     |
| Ö                   | w require<br>been si<br>should 8   | etec                 |  | <del></del>                                   |   |  |                 |   |                   |                                      |  |
| Records,            | has by   | Completed            |  |   |   |  |                 | 24a. Was                                      | sy s              | Were autop<br>prior to com<br>death? | psy findings available inpletion of cause of       |
|                     |  |                      | 05.14  |   |   |  |                 | 1 Tes   |                   | 1 Yes                                | 2×No   |
| Vital               | Physicien:<br>this certific<br>ral director,   | o Be                 | 25. Was case referred to medical examiner?  1 Tyes 2 No                        | Hospital:                                     | 0 E E E E E E E E E E E E E E E E E E E | Othe   |                 | of Death (Check only o                        |                   |                                      |  |
| of                  | Phys<br>er this<br>eral di   | $\vdash$             | 27. Manner of Death  | 28a. Date of Injury                           | 2 ER/Outpatient<br>28b. Time of         | 28c. Injury  | at at           | 0.000   | dence 6 Oth       |                                      | )  |
| Division            | Attending Is a death.  | ation                | Natural 5 Pending investigation  | (Month, Day Yea                               | ar) Injury                              | Work   | (?<br>Yes 2.∐No |   |                   |                                      |  |
| Vis                 | I or Attendi<br>after death.<br>Director; A<br>I in by the fu  | tifica               | 3 Suicide 6 Could not be determined  | 286. Place of injury -                        | At home, farm, stre                     | et, factory, office  |                 | 28f. Location (S                              | Street and Numb   | er or Rural                          | Route Number,                                      |
| ā                   | ospitel or A<br>hours after<br>unerel Direc<br>ly filled in by   | Certification:       | 4 Tronneldo  | building, etc. (Sp                            | oecily)                                 |  |                 | City or Tow                                   | m, State)         |                                      |  |
|                     | To the Hospitel or At within 24 hours after d To the Funerel Direct completely filled in by  | edical               | 29a. Certifier Certifying Phy  | vsician: To the best of my                    | knowledge, death                        | occurred at the tim  | e, date and     | place, and due to the o                       | cause(s) and ma   | nner as sta                          | ated.  |
|                     | To the H<br>within 24<br>To the F<br>complete  | ledi                 |  | and manner stated.                            |   |  |                 | occurred at the time, o                       | ate and place, a  | and due to                           | the cause(s)                                       |
|                     | V Vitl   | Σ                    | 29b. Signature and title of certifier  | 111)  |   | 29c. License   |                 |   | 29d. Date signed  | 1 (Month, D                          | Day, Year)   |
|                     |  |                      | MICI   | W.  | NW                                      | 100  | h 6 d           | 18  | 10-               | 7 -                                  | 00   |
|                     |  |                      | 30. Name and address of person who c   | W AL +  | 1 420                                   | Print)   | a. r            | 172 ( )                                       | . 1               | A . A                                | 21802  |
| 7                   | Sta  | te:                  | 31. Date filed (Month, Day, Year)  | 32. Registrar's S                             |   | ~ P.U. J.  | DUXIJ           | 1) San ()                                     | ( )               | MI                                   | 11900  |
|                     | Registr  |                      | DEC 12   |   |   | Coull .  |                 |   | 0                 |                                      |  |
|                     |  |                      |  | - Carlotte                                    | - Territory - 1                         | The state of the s |                 |   |                   |                                      |  |

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Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** DECEMBER 7 6:45 PM 2005 /Medical Ella Marie Robey 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** LA PLATA, MARYLAND

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth
Days | Hours | Min. November 17, CIVISTA MEDICAL CENTER CHARLES 9. Birthplace (State or Foreign 1922 Waryland 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 83 Director 217-12-1591 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Director Waldorf Maryland Charles 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA Apt. 214 20602 12160 Ell Lane Completed by Funeral Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiens. sant: If Item 27 Is marked other than "natural", or Items 23 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc 1 □ Never Married 2 □ Married White 1 Yes 2 No Specify Specify 3X Widowed 4 Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NDT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker At Home 8 other traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Violet Goldsborough Alfred Suite 19a. Informant's Name/Relationship (Type, Pnnt) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda M. Buckler/daughter 39394 Mt. Wolf Rd., Charlotte Hall, MD 20622 20b. Place of Disposition (Name of cemetery, crematory or other place) December 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State ö permit. Page Department of Important: If any Injury or 2005 ' 4 ☐ Donation 5 ☐ Other (Specify) Trinity Mem. Grdns. 12, Waldorf, Maryland 22. Name and Address of Facility Brinsfield-Echols F.H., P.A., 21. Signature of Funezal Service Licens 30195 Three Notch Rd., Charlotte Hall, MD 20622 ▶ 21 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner ARDIAL INFARCTION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Be Completed by Physician/Medical Examiner The law requires that the death certificate be executed burial-transi resulting in death) Last Due to (or as a consequence of Box 68760, use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? Day 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a 1 ☐ Yes 2 ☐ Mo Division of Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Tyes 2 No 3 ☐ Probably 4 ☐ Onknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed 1 Yes 1 TYAS 20 Hospital or Attending Physician: director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2₽No 1 Impatient 2 ER/Outpatient 3 DOA Medical Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 1 CHatural 5 Pending after death.

Director: A

J in by the fu investigation 1 Yes 2 No 2 Accident 3 🗌 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours a To the Funeral C l 🖨 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated 29b. Signature and title of ceptifier 29c. License number 29d. Date signed (Month, Day, Year) 12-07

State Registrar

DHMH 17 Rev 1/2001

DEC 1 2 2005

31. Date filed (Month, Day, Year)

ORIGINAL

nas

2—1 32. Redistrai s

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ABBAS A., MD 7-C POST OFFICE ROAD WALDORF, MARYLAND 20602

D-57708

|  |                            | ricac  |   |  |                                | artment of H                               |                       | •                               | •  |   |
|--|----------------------------|--|---|--|--------------------------------|--|-----------------------|---------------------------------|--|---|
|  | 1                          | For<br>State<br>Registrar  |   | ,              |                                | rtificate of l                             |                       |                                 | Reg. No. U U 5                               | 4   99  |
| Bhysiolog  |                            | Decedent's Name (First, Middle,  | Last)                                   | 0  |                                |  |                       | 2. Date of Dea                  | ath<br>Day Yea                               | 3. Time of Death                                      |
| Physician<br>/Medica   |                            | MARY   |   | KE15   | <u>S</u>                       |  |                       | DECEM                           |  | 25-6:30 PM  |
| Examine  | I,                         | A Facility Name (If not institution, DALTIMORE WASHIN                              | STON NIED                               | ICAL CEN   | TER                            | 4b. City, Town, or                         | Location of Dea       |                                 | AVNE A                                       | RUNDEZ  |
| Funeral Director   |                            | 5. Social Security Number 214-48-1567  | 6. Sex<br>1 □ M 2.T3F                   | 7. Age (In yrs. 59                                   | last birthday)<br>Yrs.         | Months Days                                | Hours Min             |                                 | n<br>y, Year) 9.8<br>1946 Ms                 | lirthplace (State or Foreign<br>Country)<br>Lryland   |
| g  |                            | Usual Residence of Decedent  |   |  |                                |  |                       | 10 25                           | 1740   110                                   |   |
| arylan<br>show   | _                          | 10a. State 10b. County   |   |  | y, Town or L                   |  |                       |                                 |  | 10d. Inside City Limits 1 ☐ Yes ※XNo                  |
| r death with the Maryland<br>ems 23s or 28s-f show<br>armust be rediffed at  | Funeral Director           | MD Anne A  | rundel                                  |  | len B                          | ırnie                                      |                       |                                 | 10g. Citizen of What                         |   |
| with   | ב                          | 474 Norvelle C   | ourt                                    |  |                                | 21061                                      |                       |                                 | USA  | oodiniy.  |
|  | lera<br>lera               | 11. Marital Status   |   | edent Ever in U                                      | .S. 13.                        | Was Decedent of Hi<br>If Yes, specify Cuba | ispanic Origin? (     | Specify Yes or No-              |  | nerican Indian,                                       |
| (0 g # H   | ב                          | 1 Never Married 2 Marrie   | d 1 □Yes<br>If Yes, G                   | XXXNo<br>ive   | Į.                             | 1 ☐ Yes 2 X No                             |                       | Tiouri, Oto.,                   | Specify:                                     | White   |
| Hyy T  | Be Completed by            | 3 ☐ Widowed 4 ▓ Divorced   | Year or E                               | Dates:   | 16a, Dece                      | dent's Usual Occup                         | ation                 |                                 | 16b. Kind of Busines                         | ss/industry   |
| 215.<br>215.<br>In 'ne 'ne 'ne 'ne 'ne 'ne 'ne   | ble                        | (Specify only highest<br>Elementary/Secondary (0-12)                               | grade completed)                        | 1-4or 5+)  | (Give                          | kind of work done of<br>DO NOT use retired | during most of wo     | orking                          |  | ·-···,  |
| d 212<br>d 212<br>filed with<br>Hyglene<br>wher the  | 000                        | 11   |   |  | Homer                          | naker                                      |                       |                                 | Own Hon                                      | ie  |
|  |                            | 17. Father's Name (First, Middle, L  |   |  |                                |  | Ida Bry               |                                 | Maiden Sumame)                               |   |
| Marylan<br>Marylan<br>12 should be<br>h and Mental<br>7 is marked c<br>traumatic eve   | 0                          | William Tyding  19a. Informant's Name/Relationsh                                   |   |  | 19b. Maili                     | ng Address (Street a                       |                       |                                 | ar, City or Town, State                      | , Zip Code)   |
| S S S S S S S S S S S S S S S S S S S  |                            | Charles Whitti   | ngton (So                               |  | _                              |  |                       | , Pasade                        | na, MD 211                                   | 22  |
|  |                            | 20a. Method of Disposition  1 Description  2 Cremation                             | 3 □Removal from                         | State  |                                | osition (Name of<br>matory or other plac   |                       | Date                            | 20c. Location - City                         |   |
|  |                            | 4 ☐ Donation 5 ☐ Other (Sp   | ecity)                                  | St.  | -                              |  |                       | -                               | Annapolis                                    | , MD  |
| Ball Permi Depending Sany Ir   |                            | 21. Signature of Funeral Service   | eg-                                     |  |                                |  | ly Avenu              | e, Annap                        | olis, MD 2                                   | 1401  |
| 16 · 4 · 4   |                            | 23a. Part1. Enter the disease, or o shock, or heart failure. List of               | complications that<br>only one cause on | caused the deat<br>each line.                        | h. Do not en                   | ter the mode of dyin                       | g, such as cardia     | ic or respiratory ar            | rest,  | Approximate<br>Interval Between<br>Onset and Death    |
| Physician /Medical   |                            | Immediate Cause (Final disease or condition resulting in death)                    | a. H                                    | poxic  | Lence of):                     | piretor                                    | y Tail                | we                              |  | Days  |
| Examiner   |                            | Companie the link and distance   | Me                                      | tasta  | tic                            | Luna                                       | a Car                 | cer                             |  | Marths  |
| De sit   | ner                        | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying | Due to                                  | (or as a conseq                                      | uence of):                     | 4  | J                     |                                 |  |   |
| 760, te be executed ysician and te burial-transit  | Examiner                   | Cause (Disease or injury that initiated events resulting in death) Last            | c                                       | (or as a conseq                                      | uence of):                     |  |                       |                                 |  |   |
| 760<br>e be<br>sicia<br>e bur  | Cal                        |  | l d                                     |  |                                |  |                       |                                 |  |   |
| 68°  | _                          | 15.551111.5  |   |  |                                |  |                       |                                 |  |   |
| Box 68' leath certificat attending phy   | an/n                       | IF FEMALE: 23b. Was decedent pregnant in the past 12 months?                       | 1 Live                                  | itcome of pregna<br>birth 2 ☐ Feta                   | ldeath 3[                      | ⊒Ectopic pregnancy                         |                       |                                 | 23d. Date of o                               | lelivery<br>Day Year                                  |
| , P.O. Box<br>that the death cert<br>eed by the attendin<br>detached for use   | ysic                       | in the past 12 months?<br>1 □ Yes 2 MNo<br>9 □ Unknown                             | 4∐Preg<br>9□ Unkr                       | nant at time of d<br>nown                            | eath 5[                        | Other (specify)                            |                       |                                 |  |   |
| S, P.  | 7                          | Part II. Other significant condition   |   |  |                                |  | en in Part I.         | 23e. Did to                     | obacco use contribute                        | to the cause of death?                                |
| Cords  | ed                         | SUPERIOR V   |   |  |                                |  |                       | 1 <b>20</b> Y                   | /es 2□No 3□                                  | Probably 4 Unknown                                    |
| Division of Vital Records, P.O. Box 68 To the Hospital or Attending Physician: The law requires that the death certifical within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phy completely filled in by the funeral director: page 2 should be detached for use as the | Completed by Physician/Med | CHRONIC OF   | 3st rucs                                | NVZ P  | ULMC                           | WARY                                       | DISEAS                | perfo                           | osy prior to<br>rmed? death                  | autopsy findings available o completion of cause of ? |
| f Vital yslcian: yslcian: ortifica director.p  | Re                         | 25. Was case referred to medical examiner?   |   |  |                                |  | 26. Place of De       | eath (Check only o              |  |   |
| of V<br>ohysic<br>this ce<br>al dire   | 9                          | 1 ☐ Yes 2 No   |   |  | ER/Outpatie                    |  | 4   Nursing           |                                 | dence 6 Other (Sp                            | pecify)   |
| OU O<br>ding Pt<br>h.<br>Atter th<br>funeral   | tion                       | 27. Manner of Death  1 Natural 5 ☐ Pending 2 ☐ Accident investig                   |   | oth, Day Year)                                       | 28b. Time o<br>Injury          | Worl                                       | γaπ<br>k?<br>Yes 2∐No | 28d. Describe r                 | now injury occurred                          |   |
| VISION Attention of death  | Certification:             | 3 Suicide 6 Could n  | ot be 28e. Plac                         | e of Injury - At h                                   | ome, farm, st                  | reet, factory, office                      |                       | 28f. Location (S<br>City or Tow | Street and Number or                         | Rural Route Number,                                   |
| Di<br>ital or<br>ral Dir<br>lled in  | Cer                        |  |   |  |                                |  |                       |                                 |  |   |
| Divi   | edical                     | 29a. Certifier 17 Certifying (Check only one) Medical E                            | :xaminer: On the I                      | e best of my kno<br>basis of examina<br>nner stated. | wiedge, dea<br>ition and/or in | ivestigation, in my o                      | pinion, death occ     | curred at the time, o           | cause(s) and manner<br>date and place, and d | ue to the cause(s)                                    |
| To t<br>with<br>To t   | Σ                          | 29b. Signature and title of certifler  | Airin                                   | MD   |                                | 29c. Licens                                |                       |                                 | 29d. Date signed (Mo                         | ,   |
|  | -                          | 30. Name and address of person v   | who completed cau                       | ise of death (Iter                                   | n 23a) (Tvne                   |  | 13274                 | 7                               | xcembe                                       | 1 7 duus  |
|  |                            | 301 Hospitel   | Drive                                   | Glen   | Bun                            | ie Mo                                      | 2106                  | 1 MARI                          | A GAVIRI                                     | 17,2005<br>AMD.                                       |
| State<br>Registra  | -                          | 31. Date filed (Month, Day, Year)  DEC 1 2   | 2005                                    | Glen<br>Registrar's Signa                            | Mr A                           | pode                                       |                       |                                 |  |   |

O5-O7924 EDUARDO RICH WHM

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Unpend item#23a-b,27, perME, G850,12-30-05 II

| ciaian   |                                       | State<br>Registrar  |  |  | Cel  | uncate t  | of Death  | 7  |  | Reg. No.   | 05_  | 1992  |
|--|---------------------------------------|---|--|--|--|---|---|--|--|--|--|---|
| ysician  | _                                     | Decedent's Name (First, Middle, L   | .ast)  | DTCII  |  |   |   | :  | 2. Date of De  |  | 2005   | 3. Time of Death 08:15 A  |
| Iedical  | _                                     | EDWARDO  . Facility Name (If not institution, g   | nive street and nur  | RICH   |  | 4b. City, Tow   | n or Location   | of Death   | TOVILLE  |  | nty of Death   |   |
| aminer   | 44                                    | 3707 34th STREE   |  | 501)   |  |   | INIER   | or Bourn   |  |  |  | ORGES CO  |
| eral   | 5.                                    |   |  | 7. Age (In yrs   | . last birthday)   | If Under 1 Ye   | ar If Unde  | r 24 Hrs.  | 8. Date of Bir   |  |  | place (State or Fore  |
| ctor   |                                       |   | 1₫M 2□F  | 43   | Yrs.   | Months Da   | ys Hours  | Min.   | 8. Date of Bir<br>(Month, Da<br>AUG • 2  | 9,1962   | 2 Vir  | ginia   |
|  |                                       | sual Residence of Decedent  Da. State 10b. County   |  | 100 C  | ity. Town or Lo  | ontion  |   |  |  |  |  | 10d. Inside City Lim  |
| IN IN  |                                       |   |  |  |  |   |   |  |  |  |  | 12∑ Yes 2 □ I   |
| unt be notified at   | M                                     | aryland Princ   | e George   | S MI.  | RAINE  | 10f. Zip Coo  |   |  |  | 10g. Citizen   | of What Cou  |   |
| 2 c  |                                       | De. Street and Number<br>B707 34th STRE   | ទ ភ <b> ហ</b>  |  |  | 2071  |   |  |  | $U \cdot S \cdot Z$  |  | intry :   |
| Iner count   | 3 11                                  | . Marital Status  | 12. Was Dece   | dent Ever in l   | J.S. 13.   | Was Decedent  | of Hispanic O   | rigin? (Spe  | cify Yes or No   | - 14. F  | lace - Ameri   |   |
|  | 3                                     | 1 ☐ Never Married 2 ☐ Married   | Armed For  | 2 X No   |  | If Yes, specify (   |   |  | Rican, etc.)   |  | Stack, White,  |   |
| 3 3  | 2                                     | 3 ₩idowed 4 Divorced  | If Yes, Give<br>Year or Da   | ites:  |  | 1⊡Yes 2⊠X   | No Specify  | y:   |  | Spe  | city: BL   | ACK   |
| t, the Medical I   | 2                                     | 15. Decedent's (Specify only highest of   | Education grade completed)   |  | 16a. Dece  | dent's Usual Oc<br>kind of work do<br>DO NOT use re                           | cupation<br>ne during mo  | st of workin   | ng   | 16b. Kind of   | Business/Ir  | ndustry   |
| all light  | -                                     | Elementary/Secondary (0-12)   | College (1-  | -4or 5+)   | ELEC:  |   | tired)  |  | -  |  |  |   |
|  |                                       | 5 Fathada Nama (First Middle La   | nt)  |  | ELEC.  | LRIAN   | 18 Moth   | nor's Name   | (First, Middle,  |  |  | MES/REPA  |
| No.  | ž                                     | 7. Father's Name <i>(First, Middle, La:</i><br>RUSSELL BURTO  |  |  |  |   |   |  | A VENE   |  | •  |   |
| of L   |                                       | 9a. Informant's Name/Relationship   |  |  | 19b Mailir   | ng Address (Str   |   |  |  |  |  | o Code)   |
| trau   |                                       | IRGINIA VENEY   |  |  | 1007 11121111  | · · · · · · · · · · · · · · · · · · ·   |   |  |  | ., e., e.  | ,,,  | ,   |
| other traumatic  | _                                     | Da. Method of Disposition   |  | 20b.   | Place of Dispo   | sition (Name o  |   | D  | ate  | 20c. Locatio   | n - City or T  | own, State  |
| 2m   |                                       | 1 ☑ Burial 2 ☐ Cremation 3<br>4 ☐ Donation 5 ☐ Other (Spec  |  |  |  | natory or other<br>laptist  |   | 11/29  | /05  | EMMER  | TON V.   | IRGINIA   |
| eny injury o   | 2                                     | Signatur of Funeral Service Lic   |  | 33   |  | 2. Name and Ad  |   |  | ERRY (   |  |  |   |
| è a  |                                       | 1271.1  | 1/www  | 7  | 67   | 84 MAR  | YBALL   | ROA  | DLANC  | ASTER  | VA.2   | 2503  |
| the burial-transit and the burial-transit and the burial Examiner  | e re                                  | equentially list conditions, any, leading to immediate ause. Enter Underlying ause. [Or. are or injury nat initiated events soulting in death) Last   | onephriquence of):   |  |  |   |   |  |  |  |  |   |
| buri.  | _                                     | 3   | <u> </u>   |  |  |   |   |  |  | 224 (  | Date of deliv  |   |
| for use as the bur   | -                                     | FEMALE: 3b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown   |  | nth 2 ∏ Feta<br>ant at time of o   | al death 3   | Ectopic pregna<br>Other (specify  |   |  |  |  | Month  | ery<br>Day Year   |
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| pletely filled in by the funeral director, page 2 should be detached for use as the but and its afficial Certification. To Be Completed by Physician/Medical | Fe   Pe   Pe   Pe   Pe   Pe   Pe   Pe | 3b. Was decedent pregnant in the past 12 months?  1   | Hospital: 1 In It is a building to de la la la la la la la la la la la la la   | nth 2 Fetant at time of own  ath but not resemble to the patient 2 for finiury of Injury - At high, bay Year)  best of examin  | al death 3 death 5 sulting in the usual sulting in  | Other (specify  nderlying cause  at 3 DOA 28c. I  M 28c. I  westigation, in n | given in Part  26. Plac Other: 4 N  Nijury at Nork?  Yes 2 Ce                     | De of Death  Jursing Hon  No  2  And place, a              | 24a. Was autop period 12 Yes  (Check only cone 5 Reside 8d. Describe 1 City or Towns at the time,  | obacco use covered to the second of the seco | ontribute to to 3 Prole  3 Prole  b. Were autoprior to codeath?  Yes  Other (Special Special Year the cause of death? bably 4 □Unknot bably 4 □Unknot baysy findings availal ampletion of cause of 2□ No  (b) SCENE  al Route Number,  |
| neral director, page 2 should be detached for use as the bur<br>nr. To Be Completed by Physician/Medical   | Per 2:                                | 3b. Was decedent pregnant in the past 12 months?  1   | Hospital: 1 In It is a building to de la la la la la la la la la la la la la   | nth 2 Fetant at time of own  ath but not resemble to the patient 2 for finjury of Injury - At high, bay Year)  of Injury - At high, etc. (Special of examination stated.   | al death 3 death 5 death 5 death 5 death 5 death 5 death 5 death 5 death 5 death 5 death 5 death 6 dea | ot 3 DOA 28c. I   | given in Part  26. Plac Other: 4 N  Nork?  Yes 2 Ce  a time Jate 3 by opinion, de | De of Death  Aursing Hon  No  2  And place, a lath occurre | 24a. Was autoperformed to the control of the contro | obacco use covers 2 No 241 241 25 No | ontribute to to 3 Proloto. Were autoprior to codeath?  Other (Special Properties of the Company  | Day Year  the cause of death?  bably 4 □Unkno  popy findings availa  impletion of cause of the cause of the cause of death?  SCENE  al Route Number,  othe cause(s)  Day, Year)   |

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year Physician DECEMBER 3, 2005 7:40 A. RUPPENKAMP MARY F. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner CUMBERLAND ALLEGANY 14801 VIEWCREST ROAD, S.W. If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex Funeral Months 1 □ M 2 T F 87 199-14-2080 26, 1918 PENNSYLVANIA Director Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10a. State 10h County 23a or 28a-f ehow r then "naturel", or iteme 23a or 28a-f eho: the Medical Evantinar must be notified at 1 ☐ Yes 2 ☑ No CRESAPTOWN Directo ALLEGANY MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21502 U.S.A. 12807 VIEW AVENUE KNOBLEY death Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: WHITE 1 ☐ Yes 2 X No Specify: δ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry RETAIL GROCERY Flementary/Secondary (0-12) College (1-4or 5+) STORE CLERK 9 other 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) permit. Peges 1 and 2 should be file Department of Heelith and Mental Hy Importent: If Item 27 Is marked oth eny Injury or other treumatic event QRES. Be JOHNSON ESTHER ROBINETTE ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) GERALD F. RUPPENKAMP /HUSBAND 12807 KNOBLEY VIEW AVENUE, CRESAPTOWN, MD 21502 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 12/06/2005 FLINTSTONE, MD M.S.V.C.-ROCKY GAP 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
UPCHURCH FUNERAL HOME, P.A. 21. Signature of Funeral Service Licensee 202 GREENE STREET, CUMBERLAND, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** a Anaplastic Conversion of a Papillary Thyroid Cancer Weeks disease or condition resulting in death) /Medical Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine attending physicien end for use as the burial-transit Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by Coronary Artery Disease, Diabetes Mellitus 2 No 3 Probably 4 Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy 1 ☐ Yes 20 daughter's Be 25. Was case referred to medical 26. Place of Death (Check only one, Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) residence Certification: To 1 Tes 2 No 3 DOA andin,
v death.
vor: After th.

9 funeral dir 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Injury 1 Natural 5 Pending To the mosphers.
within 24 hours after death.
To the Funeral Director: Aft 1 Tes 2 No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of fnjury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide t Contifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the causa(e) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 12-06-05 D0054411 6 completed cause of death (Item 23a) (Twe, Print) Memorial Ave, Cumberland, MD 2/502 Name and address of arson who 500 alkins 32. Agistrar's Signature 31. Date filed (Month, Day, Year) State DEC 0 7 2005 Registrar

Amended #23b, nls, Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 12/16/05, Allegany Co. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 19:25PM Charles Allan Robison /Medical 4c. County of Death 4b. City Town or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner If Under 1 Year MCT Ed If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 M 2□F Months Days Min Yrs. Director 215-34-4300 Usual Residence of Dec 70 27-Feb-1935 Maryland Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: if Item 27 is marked other than "natural", or Items 23a or 28a-f ehow ant: if Item 27 is marked other than "natural", or phose faurnal to event, the Medical Exptr. are marken inviting all 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 □ No Director Maryland Allegany Frostburg Maryana 10e. Street and Number 7 Maple Drive 10f. Zip Code 10g. Citizen of What Country? U.S.A. 14. Race - American Indian. White, etc. Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Marned Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify. 3 ☐ Widowed 4 ☐ Divorced White 16b. Kind of Business/industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) bar tender veteran's organization 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 2 Orval Robison Thelma Martin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7 Maple Drive Wanda Robison wife Frostburg Maryland 21532 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State permit. Page Depertment o Important: If any Injury or once. 4 ☐ Donation 5 ☐ Other (Specify) 15-Dec-2005 Flintstone Maryland Veteran's Cemetery 21. Signature of Euneral Service Lices 22. Name and Address of Facility ohe Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, phock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence physician and s the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed P.O. Box 68760. IF FEMALE: for use 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 2 No cate has been sig , page 2 should b 3 Probably 4 Unknown Be Completed 24a. Was an autopsy perform 1 ☐ Yes 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient ER/Outpatient Certification: To 3 DOA 27. Manner of Death 1 Natural 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred After Injury 5 Pending 1 Yes 2 No To the Hospital or Attendi within 24 hours after death. To the Funeral Director; A investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide 29a. Certifier X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 00062429 5 of person who completed cause of death (Item 23a) (Type, Print) "Ave. cumberland, MD MD 47 VICO virginia Registrar

|                   |  |                | 1 - For State Registrar   | State of Marylan  | d / Depa  | artment o                          |  | and M                    | ental Hyg                                  | iene                               | 05                                       | 41995   |
|-------------------|--|----------------|---|---|---|------------------------------------|--|--------------------------|--|------------------------------------|--|---|
|                   | Physici  | ALC: 1         | Decedent's Name (First, Middle, Last,     John Richard Rome   |   |   |                                    |  |                          | 2. Date of Death<br>Month<br>Decemb        |                                    | 2005                                     | 3. Time of Death 10:30a M                     |
|                   | /Medic<br>Examir   |                | 4a. Facility Name (If not institution, give   | street and number)  |   | 4b. City, Tov                      | vn, or Location of                               | of Death                 |  |                                    | ty of Death                              | 10.000  |
|                   |  | 4              | Holy Cross Hospit   | al  |   | Silv                               | er Spri  |                          |  | Mon                                | tgome                                    | ry  |
|                   | Funeral<br>Director  |                |   | 7. Age (In yrs. 55  |   | If Under 1 Y<br>Months Da          | ear If Under<br>ays Hours                        | Min.                     | 8 Date of Birth<br>(Month, Day,<br>Oct. 25 | <sup>Уваг)</sup><br><b>, 1</b> 950 | Cour                                     | lace (State or Foreign<br>htry)<br>ington, DC |
|                   | and and  |                | Usual Residence of Decedent  10a. State 10b. County   | 10c. Cit  | y, Town or Lo   | ocation                            |  |                          |  |                                    | 1  | 0d. Inside City Limits                        |
|                   | Mary   | ţŏ             | Maryland Prince   | George's  | Belts   | ville                              |  |                          |  |                                    |  | 1 ☐ Yes 2 🖾 No                                |
|                   | or 28s   | Director       | 10e. Street and Number  |   |   | 10f. Zip Co                        | de   |                          | 10   | g. Citizen o                       | f What Cour                              | ntry?   |
|                   | 23a c  | rain           | 4403 Romlon Stree   |   |   | 207                                |  |                          |  | US                                 |  |   |
| 21215-0036        | 72 hours after death with the Maryland<br>"naturel", or Items 23a or 28a-f show<br>idical Examinar must be notified at | by Funeral     | 11. Marital Status  1 Never Married 2 Marned  3 Widowed 4 Divorced  | 12. Was Decedent Ever in U<br>Amed Forces?<br>↑☐ Yes 2 □ No<br>If Yes, Give<br>Year or Dates: 197     | 4-  | If Yes, specify                    | of Hispanic Ori<br>Cuban, Mexicar<br>No Specify: | n, Puerto P              | cify Yes or No-<br>Rican, etc.)            | В                                  | ace - Americ<br>ack, White,<br>hify:Whit | etc.  |
| 5-0               | 72   | Completed      | 15. Decedent's Edu<br>(Specify only highest grad  | cation<br>le completed)   | (Give   | dent's Usual O                     | one during mos                                   | t of workin              | g  | 6b. Kind of                        | Business/In                              | dustry  |
| 7                 | within<br>ene.<br>then   | mpl            | Elementary/Secondary (0-12)   | College (1-4or 5+)  | life.   | DO NOT use re                      | etired)  |                          |  | Todos                              | -3 C-                                    |   |
|                   | the Tygin  |                | 17. Father's Name (First, Middle, Last)   | 2   | Pro   | curemen                            | 18 Mothe   |                          | (First, Middle, N                          |                                    |  | vernment                                      |
| and               | d be f   | o Be           | John Richard Rom  |   |   |                                    |  |                          |  |                                    |  |   |
| Maryland          | 1 and 2 should<br>dealth and Mer<br>em 27 le marke<br>ther treumatic   | 우              | 19a. Informant's Name/Relationship (Ty  | rpe, Print)   | 19b. Mailir   | ng Address (St                     | reet and Numbe                                   | er or Rural              | Route Number,                              | City or Tow                        | n, State, Zip                            | Code)   |
|                   | and 2<br>salth a<br>n 27 le  |                | Joan L. Romett/ S   |   |   |                                    |  | 7e, 0                    | lney, Ma                                   | arylan                             | d 208                                    | 32  |
| ore               |  |                | 20a. Method of Disposition  | 20b. P  | Place of Dispo<br>emetery, crer                                     | sition (Name of<br>matory or other | of<br>place)                                     | Dece                     | mber 9,                                    | Oc. Location                       | - City or To                             | wn, State                                     |
| Ĕ                 | Pages<br>ment of land: If Its  |                | 20a. Method of Disposition  1 Burial 2 Cremation 3 F  4 Donation 5 Other (Specify)  | Metro   | politan   | Cremato                            | ry   |                          |  | Alexan                             | dria,                                    | Virginia                                      |
| Baftimore,        | permit.<br>Depart<br>Import<br>eny Inj   |                | 21. Signature of Funeral Service Licens   | D'Cole  | <b>f</b> 5  | Name and A<br>rancis<br>00 Univ    | ddress of Facility<br>J. Coll<br>versity         | ins<br>Blvd              | Funeral<br>, W, Si                         | Home<br>Lver S                     | Inc<br>pring                             | ,MD 20901                                     |
|                   | Physician  |                | 23a. Part1. Enter the disease, or compl<br>shock, or heart failure. List only of<br>Immediate Cause (Final<br>disease or condition<br>resulting in death) | i ations that caused the death<br>re-ause on each line.<br>Liver C                                    | 0.  | er the mode of                     | ,  | cardiac or               | respiratory arre                           | st,                                |  | Approximate Interval Between Onset and Death  |
| 1                 | /Medical<br>Examiner   |                |   | Hepato  | uence of):  | al                                 | Sey  | nal                      | ron  | e                                  |  | ulls.   |
| į.                | uted ansit   | Examiner       | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events                         | Due for as a consequence Hepatt   | Hepatorenal Syndus  Due (or as a consequence of):  Hepatic Encephop |                                    |  |                          |  |                                    |  | was.  |
| ,097              | te be executed<br>ysicien and<br>te burial-transit   | cal Exa        | resulting in death) Last  | Due to (or as a consequence Coaq wl   | uence of):  | Imig                               | ,  |                          |  | 7                                  |  | ueks  |
| 89                |  | -              |   | ,   | 7   | J                                  |  |                          |  |                                    |  |   |
| P.O. Box          | that the death certificat<br>ed by the attending phy<br>detached for use as th   | Physician/Med  | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown   | 23c. If yes, outcome of pregna<br>1 □ Live birth 2 □ Feta<br>4 □ Pregnant at time of d<br>9 □ Unknown | Ideath 3□   | Ectopic pregn<br>Other (specif)    |  |                          |  |                                    | ate of delive                            | ny<br>Day Year                                |
| Vital Records, P. | 8 E 6  | by             | Part II. Other significant conditions con   | ntributing to death but not res   | ulting in the u   | nderlying cause                    | e given in Part 1.                               |                          |  | acco use co                        |  | e cause of death?                             |
| COL               | w requir<br>been sl<br>should  | lete           |   |   |   |                                    |  |                          | 24a. Was an                                | 24b                                | . Were auto                              | psy findings available                        |
| Re                | o ~ g  | Completed      |   |   |   |                                    |  |                          | autopsy                                    | ed?                                | prior to cor<br>death?                   | npletion of cause of                          |
| ta                | ilcian: Th<br>certilicate<br>rector, pag   | 0              | 25. Was case referred to medical  |   |   |                                    | 26. Place  | of Death                 | 1 ☐ Yes 2<br>(Check only one               |                                    | 1 🗆 Yes                                  | 2-140   |
| <u> </u>          | Physician:<br>this certific<br>ral director,   | To B           | examiner?   | fospital: Unpatient 2   | ER/Outpatien  | t 3 DOA                            | Othor  |                          | e 5 Resider                                |                                    | ther (Specify                            | ′)  |
| Division of       | Jing<br>After<br>fune  |                | 27. Manner of Death 1. Natural 5 Pending 2 Accident investigation   | 28a. Date of Injury<br>(Month, Day Year)  | 28b. Time of<br>Injury  |                                    | Injury at<br>Work?<br>1  Yes 2                   |                          | 8d. Describe how                           | v injury occu                      | irred                                    |   |
| Divis             | 5 th 2 th 3  | Certification: | 3 Suicide 6 Could not be<br>4 Homicide determined   | 28e. Place of Injury - At he building, etc. (Specify  | ome, farm, str<br>v)  | eet, factory, off                  | ice  | 2                        | 8f. Location (Str.<br>City or Town,        |                                    | nber or Rura                             | l Route Number,                               |
|                   | To the Hospitel or Attend within 24 hours after death To the Funerel Director: completely filled in by the             | edical (       | (Check only ane)  | ner: On the basis of examina<br>and manner stated.  | wladge, death<br>tion and/or inv                                    | vestigation, in r                  | ie time, data an<br>ny opinion, dea              | d place at<br>th occurre | d at the time, da                          | te and place                       | ranner as st<br>, and due to             | ated.<br>the cause(s)                         |
|                   | To the within To the comple  | ž              | 29b. Signature and title of certifier   |   |   | 29c. Lic                           | cense number                                     |                          | 29   | d. Date sign                       | ed (Month, I                             | Day, Year)                                    |
|                   | EXI  |                | A. Nau  | uaz.  |   | Di                                 | 5098   | 7                        |  | 12/                                | 9/0                                      | ) ·   |
| _                 | <b>7</b> 11  |                | 30. Name and address of person who co   | mpleted cause of death (Item  | PO (Type,   | BOX                                | 83819  | 6                        | aith                                       | ersb                               | wq                                       | 05 ·<br>MD 2688                               |
| 100               | Sta<br>Registr   |                | 31. Date filed (Month, Pay, Year) 200   | 3 Registrar's Signa   | ture  | del                                |  |                          |  |                                    | 1  |   |

|                                     |  |                  | 1 - For State Registrar  | State of Ma  |  | d / Depa   |   | lealth and I  | Mental Hyg   |                              | 1100   |  |
|-------------------------------------|--|------------------|--|--|--|--|---|---|--------------|------------------------------|--|--|
| *                                   | Physici<br>/Medio<br>Examir  | al               | Decedent's Name (First, Middle, Last     Aa. Facility Name (If not institution, give   | LaRay Virgin   | ia Rich  | ardson   | 4b. City, Town, o   | r Location of Deat  |              | 2 2005 Ye 4c. County of C    | 3:50PM M   |  |
|                                     | Funeral<br>Director  |                  | 5. Social Security Number 6. Se 217-10-7543  | 3 Castle Hill  x  ☐ M 200 F 7. Age                                     | (In yrs. la  | est birthday)<br>Yrs.  | If Under 1 Year<br>Months Days                                | Lonac<br>If Under 24 Hrs<br>Hours Min.                        |              | 1                            | Allegany  Birthplece (State or Foreign Country)  West Virginia |  |
|                                     | he Maryland<br>8a-f show   | Director         |  | gany   | 10c. City  | , Town or Lo   |   | Lonaconing  |              | Og. Citizen of Wha           | 10d. Inside City Limits 1 ★Yes 2 □ No                          |  |
| 36                                  | 2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other then "naturel", or items 23a or 28a-f ehow aumatic event, the Medical Examiner must be notified at   | by Funerai Dir   | 11. Marital Status  1 Never Married 2 Married  | stle Hill  12. Was Decedent E Armed Forces? 1 □ Yes 2 ☑ N If Yes, Give |  | 1  | Nas Decedent of H   | 21539<br>ispanic Origin? (S<br>an, Mexican, Puerl<br>Specify: |              | 14. Race - /                 | J.S.A. American Indian, Vhite, etc.  White                     |  |
| Maryland 21215-0036                 | within 72 hours<br>one.<br>then "naturel"  | Completed b      | 3 Widowed 4 Divorced  15. Decedent's Edi (Specify only highest grace)  Elementary/Secondary (0-12)   | Year or Dates: ucation te completed) College (1-4or 5                  | +)   | 16a. Decec<br>(Give<br>life. L   | dent's Usual Occup<br>kind of work done<br>OO NOT use retired | ation<br>during most of wor<br>t)<br>Textile                  | rking        | 16b. Kind of Busin           |  |  |
| yland 2                             | ould be filed via the filed varked other insticevent, It   | To Be Co         | 17. Father's Name (First, Middle, Last)  | Albert Bland   |  |  |   | 18. Mother's Nar  |              | ence Kallmye                 | r  |  |
| ore, Mar                            | permit. Pages 1 and 2 should by Department of Health and Menta Important: if item 27 is marked any injury or other traumatic espace.   |                  | 19a. Informant's Name/Relationship (T)  David S. Beeman  20a. Method of Disposition  1 ☑ Buriat 2 ☐ Cremation 3 ☐ I  | - Executor   | 20b. Pla   | ace of Dispo<br>metery, cren   | 6008 St. Mai<br>sition (Name of<br>natory or other place      | ry's Church   | Terrace, Lon | 20c. Location - City         | ryland, 21539  |  |
| Baltimore,                          | permit. Pag<br>Department<br>Important:<br>any injury c  |                  | 21. Signature of Funeral Service Licens  License Modes   | )  |  |  | rg Memorial  Name and Addre                                   | ss of Facility<br>-McKenzie                                   | Funeal Hom   | e P.A., 8 Eas                |  |  |
| 68760,                              | Physician /Medical Examiner sthe parity string in the private of t | edicai Examiner  | 23a. Raft1. Enter the disease, or comp shock, or heart failure. List only of limediate Cause (Finat disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | a. Left vo   | entr<br>a consequ<br>c an                                | icula<br>ence of):<br>d mit<br>ence of):   | _   | g, such as cardiad  |              |                              | Approximate Interval Between Onset and Death  Uk yrs           |  |
|                                     | that the death certificat<br>ed by the attending phy<br>detached for use as th   | by Physician/Med | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes → No 9 ☐ Unknown  | 23c. If yes, outcome<br>1 Live birth<br>4 Pregnant at<br>9 Unknown     | 2 Fetel  | death 3  | Ectopic pregnancy<br>Other (specify)                          |   |              | 23d. Date of<br>Month        | delivery<br>Day Year   |  |
| Division of Vital Records, P.O. Box | aw requires<br>ts been sign<br>2 should be   | Completed by Pt  | Pan II. Other significant conditions control tricuspid rec   | 1 TY   | es 2 No 3  | te to the cause of death?  ] Probably 4 Unknown  a autopsy findings available to completion of cause of h? |   |   |              |                              |  |  |
| ta                                  | an: The  | Be Co            | 25. Was case referred to medical   | -  | performed 1 ☐ Yes 2  26. Place of Death (Check only one) |  |   |   |              |                              | Yes 2□ No  |  |
| <b>\S</b>                           | nysicia<br>nis cer<br>direct   | To B             | ovaminer?  | Hospital:<br>1 ☐ Inpatie   | nt 2 🗆 E   | R/Outpatien  | t 3 DOA Oth   | 0.5   |              | ence 6 Other (               | Specify)   |  |
| ivision o                           | To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: Atter this certificate ha completely filled in by the funeral director, page   | Certification:   |  |  |  |  |   |   |              |                              |  |  |
| Ļ                                   | To the Hospital of within 24 hours a To the Funeral Completely filled in   | Medical Ce       |  |  |  |  |   |   |              |                              |  |  |
|                                     | Toth<br>Toth<br>comp   | Σ                | 29b. Signature and title of certifier  30. Name and address of person who certifier  | ompleted rause of di   | eath (Item   | 23a) (Tyne   | D 09  |   |              | 9d. Date signed (M<br>Dec 13 |  |  |
|                                     | 3<br>Sta   | ate              | Paul Snow, M.  31. Date filed (Month, Day, Year)   | D. Dpty 32. Registra   | Med  | Ex   |   | rd St C   | umberla      | nd 2150                      | 2  |  |

|            |   |   |  | S            | tate o                   | f Marylar                                     |                  | rtment of<br>tificate of      |                        | nd Me       |   | iene   | 5 1         | 1997                                      |  |  |
|------------|---|---|--|--------------|--------------------------|---|------------------|-------------------------------|------------------------|-------------|---|--|-------------|---|--|--|
|            |   |   | 1. Decedent's Name (First, Middle  | e, Last)     |                          |   |                  |                               |                        | 2           | . Dete of Deet                          | n  | V           | 3. Time of Death                          |  |  |
|            | Physicia  |   | DONNA JEAN   | RECK         | ART                      |   |                  |                               |                        |             | Month<br>Dec                            | <sub>Деу</sub>                                   | Year 2005   | 8:45 am                                   |  |  |
|            | /Medica<br>Examine  |   | 4a Fecility Neme (If not institution   | , give stree | et end nu                | mber)   |                  |                               | 4b. City, Tow          |             | tion of Deeth                           | 4c. County                                       |             | -   |  |  |
| 1          |   |   | 325 Coolidge   | Ave          |                          |   |                  |                               | 0ak                    | land        |   | Garr   | ett         |   |  |  |
|            | Funeral   |   | 5. Social Security Number  | 6. Sex       | alsh e                   | 7. Age (In yrs.                               | -                | If Under 1 Yea<br>Months Days |                        | Min.        | . Date of Birth<br>(Month, Dey,         | Year)  |             | place (State or Foreign                   |  |  |
|            | Director  |   | 220 32 4917  | 1□ M         | 200                      | 75  | Yrs.             |                               |                        |             | July 19                                 | 1930   | MD          |   |  |  |
|            | pu s  | -   | Usuel Residence of Decedent  10a. State 10b. County  |              |                          | 10c. Ci                                       | ty, Town or Loc  | ation                         |                        |             |   |  |             | 10d. Inside City Limits                   |  |  |
|            | sho<br>d an   | ۱   |  |              |                          |   |                  |                               |                        |             |   |  |             | 1⊠Yes 2□No                                |  |  |
|            | 28a-  | 2   | Md Garre  10e. Street end Number   | t t_         |                          | Ua  | akland           | 10f. Zip Code                 |                        |             | 10                                      | Og. Citizen of                                   | Whet Cour   | ntry?                                     |  |  |
|            | A P P   | 5   |  |              |                          |   |                  |                               | 01550                  |             |   |  |             | .,  |  |  |
|            | ne 23   | era   | 325 Coolidge   | e Ave        | Was Dec                  | edent Ever in U                               | I,S. 13. W       | as Decedent of                | 21550<br>Hispanic Orig | in? (Specif | fy Yes or No-                           | USA<br>14. Rac                                   | ce - Americ | can Indian,                               |  |  |
| (0         | r her   | 5   | 1 Never Merried 2 Marr   | ied          | Armed Fo                 | orces?<br>2 ⊈No                               | If               | Yes, specify Cu               | ban, Mexican,          | Puerto Rio  | can, etc.)                              |  | ck, White,  |   |  |  |
| 036        | urs a   | 2   | 3 ☐ Widowed 4 ☐ Divorced   |              | lf Yes, Gir<br>Year or D | ve<br>lates:                                  | 1                | ☐ Yes 258 No                  | Specify:               |             |   | Specif   | y Whi       | te  |  |  |
| 21215-0036 | within 72 hours after death with the Maryland<br>ene.<br>than "naturel, or items 23s or 28s-f show<br>he Medical Exeminer must be notified at   | Completed by Funeral Director   | 15. Deceden  |              |                          |   | 16a. Deced       | ent's Usual Occu              | pation                 | of working  |   | 16b. Kind of B                                   | usiness/In  | dustry                                    |  |  |
| 21         | en.   |   | Elementery/Secondary (0-12)  | <del>-</del> | College (                | 1-4or 5+)                                     | life. D          | O NOT use retir               | ed)                    | or working  |   | 77   | _1_2        |   |  |  |
|            | ygien<br>Per th   | 5   |  | J            |                          |   | H                | ousewife                      | 1                      |             | Homemaking                              |  |             |   |  |  |
| pu         | d outh  | e l   | 17. Fether's Neme (First, Middle,  | Last)        |                          |   |                  |                               | 18. Mother             | r's Name (F | e (First, Middle, Maiden Sumame)        |  |             |   |  |  |
| yla        | 2.should be filed within 72 hours aft<br>and Mental Hygiene.<br>Is marked other than "naturel, or<br>raumatic event, the Medical Exem-  | 2   | Alvin Casteel  |              |                          |   | 1                |                               |                        | 1 Wel       |   | th<br>ute Number, City or Town, State, Zip Code) |             |   |  |  |
| Maryland   | 12.sh<br>hand<br>is m   | 1   | 19a. Informant's Neme/Relations  |              | Print)                   |   |                  | ,                             |                        |             |   |  |             | Code)                                     |  |  |
|            | ss 1 and 2. should be filed within 72 hours after death with the Marylar of Health and Mental Hygiene. Itam 27 is marked other than "naturel", or items 23s or 28s-f show other traumatic event, the Medical Examinar must be notified at | 1   | Darvin Reckar  20a. Method of Disposition  | t            |                          | 20b. F  | Jace of Dispos   | Coolide                       | e Ave                  |             | and, M                                  | d 215.   |             | own. State                                |  |  |
| 5          |   |   | 1 Burial 2 ACremation 3 Removal from State 4 Donation 5 Other (Specify)  cemetery, ciematory or other place)  Cumberland Crematory 12/ 17/05 Cum |              |                          |   |                  |                               |                        |             |   |  |             | •   |  |  |
| Baltimore, | permit. Pege<br>Depertment of<br>Important: if<br>any Injury or<br>once.  | 1   | 21. Signature of Funeral Service   |              | dock-D                   |   |                  |                               |                        |             |   |  |             |   |  |  |
| Ba         | permit. Depertrimports any Inje   | 1   | 1 (lanual.   | 1 V          | 3.                       | 10 6  | 5                | Name and Add                  |                        | Dul         | land,                                   |  | 550         |   |  |  |
|            |   | +   | 23a. Part . Enter the disease, or  |              |                          | Approximate                                   |                  |                               |                        |             |   |  |             |   |  |  |
|            | Physician   | shock, or heart failure. List only one cause on each line.  |  |              |                          |   |                  |                               |                        |             |   |  |             | Interval Between<br>Onset and Death       |  |  |
|            | /Medical  |   | Immediate Cause (Final disease or condition  |              | ma+                      | 20+2+1  | a bro            | ast ca                        | naor                   |             |   |  | !           | 3 vrs                                     |  |  |
|            | Examiner  |   | resulting in death)  | a            | IIIC U                   |   | or as a consequ  |                               | IICEL                  |             |   |  |             | 3 yrs                                     |  |  |
|            | p = .   | ne.   |  |              |                          |   |                  |                               |                        |             |   |  |             |   |  |  |
|            | ceta be executed physician and the bunal-transit  | Examiner  | Sequentially list conditions, if eny, leading to immediate   | <b>7</b> "   |                          | Due to (d                                     | or es e consequ  | ence of):                     |                        |             |   | · · · · · · · · · · · · · · · · · · ·            |             |   |  |  |
| 68760,     | be ex   |   | cause. Enter Underlying<br>Cause (Disease or injury  | c            |                          |   |                  |                               |                        |             |   |  | -           | ····                                      |  |  |
| 387        | phys<br>s the   | adical  | that initiated events<br>resulting in death) Last  |              |                          | Due to (c                                     | r as a consequ   | ence of):                     |                        |             |   |  | 1           |   |  |  |
| _          | deeth certific<br>e attending p<br>ed for usa as  | 2   |  | d            |                          |   |                  |                               |                        |             |   |  |             |   |  |  |
| Вох        | atter   for u   | CIBIC   |  |              |                          |   |                  | 4-4-2                         |                        |             | ook Bidad                               |  | -4-514-4    | a the account of steeth 2                 |  |  |
| o.         | 0 0 %   | rnysician/m   | Part II. Other significant condition   | ns contribu  | iting to de              | eath but not res                              | ulting in the un | denying cause g               | IVON IN Part I.        |             |   | s 2XNo   |             | o the cause of death?                     |  |  |
| <u>α</u>   | F # D .   | D A   |  |              |                          |   |                  |                               |                        |             | ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, | S 222110   | 3_110       | DEDITY 4 DINGIOWII                        |  |  |
| Records,   | n signe   | D D   |  |              |                          |   |                  |                               |                        |             | 24a. Was ar                             | autopsy  | 24b. W      | ere autopsy findings<br>vailable prior to |  |  |
| ပ္ပ        | law requias been  | Completed   |  |              |                          |   |                  |                               |                        |             | perioni                                 | 100 :  | co          | mpletion of cause death?                  |  |  |
| æ          | Tha law<br>ate has<br>page 2  | Ę   |  |              |                          |   |                  |                               |                        |             | 1 UY6                                   | s <b>X</b> □No                                   | 1[          | ☐Yes 2☐No                                 |  |  |
| Vital      | ysician: Tha tis certificate he director, page  |   | 25. Was case referred to medical   |              |                          |   |                  |                               | 26. Place              | of Death (0 | Check only one                          | 9)   |             |   |  |  |
| <b>Ž</b>   | Physician:<br>this certific<br>ral director,  | examiner? 1 Yes 2XX No  Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA  Other: 4 Nursing Home 5 XResidence 6 Other (Specify)   |  |              |                          |   |                  |                               |                        |             |   |  | fy)         |   |  |  |
| n of       | The The   | 27. Manner of Deeth 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury Work?   |  |              |                          |   |                  |                               |                        |             |   | w injury occur                                   | red         |   |  |  |
| Sio        | Attending<br>or deeth.<br>octor: Afte<br>by the fune  | 27. Manner of Deeth 1 Naturel 2 Accident 3 Suicide 4 Homicide 28a. Date of Injury (Month, Dey Year) 28b. Time of Injury M 28b. Time of Injury M 28b. Time of Injury M 28b. Time of Injury M 28b. Injury at Work? 1 Ves 2 No 28b. Place of Injury - At home, farm, street, factory, office 28f. Location (Street, factory) 28d. Describe how City or Town, |  |              |                          |   |                  |                               |                        |             |   |  |             | 10  |  |  |
| Division   | or Att  |   | 4 ☐ Homicide determ  | ined 2       | 8e. Place<br>buildi      | e of Injury - At h<br>ng, etc. <i>(Specii</i> | ome, farm, stre  | et, factory, office           | •                      | 281         | City or Town                            |  | )Br Or Hure | ei Houte Number,                          |  |  |
|            | ours s  | 2   | 29a. Certifier 1⊠ Certifvin  | g Physicia   | n: To the                | best of my kee                                | wiedge death     | occurred at the               | time, date end         | I place and | d due to the ca                         | use(s) and m                                     | anner se e  | stated                                    |  |  |
|            | To the Hospital or Atlendii within 24 hours after deeth. To the Funeral Director: A complataly filled in by the t   | edical  |  | Examiner:    | On the ba                |   |                  | estigation, in my             |                        |             |   |  |             |   |  |  |
|            | within<br>To the  | Σ   | 29b. Signature end title of certifie   | //           | 1.                       |   |                  | 29c. Licer                    | nse number             |             | 1 29                                    | 0d. Date signe                                   | d (Month,   | Day, Year)                                |  |  |
|            |   |   | > / Jana ld  | KIC          | hte                      | 22  |                  | צע                            | 0033                   |             | 1 2                                     | 14-2   | CUU         |   |  |  |
| •          | 1.  |   | 30. Name end eddress of person   | who compl    | eted caus                | se of deeth (Iter                             | n 23e) (Type, F  | rint)                         |                        |             |   |  |             |   |  |  |
|            | 4   |   | Donald R. R:   | chte         |                          |   |                  | emoria                        | 1 Driv                 | ve Oa       | akland                                  | L, MD  | 2155        | 50  |  |  |
|            | State   |   | 31. Date filed (Month, Dey, Year)  |              | 32. R                    | legistrer's Signa                             |                  | A 00                          |                        |             |   |  |             |   |  |  |
|            | Registra  | r   | DEC 1  | 4 201        | oh 1                     | THE WALL                                      | AT A             | 3300                          |                        |             |   |  |             |   |  |  |

DHMH 16 Rev 6/95

ORIGINAL

|            |  |                | 1 - For<br>State<br>Registrar  |                         |  | Marylar                          |                     | oartmen<br>e <i>rtificat</i>          |                    |                                     |              |                                | Reg. No              |                     | 5 1                         | 199                              | 8        |
|------------|--|----------------|--|-------------------------|--|----------------------------------|---------------------|---------------------------------------|--------------------|-------------------------------------|--------------|--------------------------------|----------------------|---------------------|-----------------------------|----------------------------------|----------|
|            | Physici  | an             | Decedent's Name (First,  |                         | Í  |                                  |                     |                                       |                    |                                     | }            | 2. Date of De<br>Month         | Da                   |                     | Year                        | 3. Time of                       |          |
|            | /Media   | cal            | James Deane  |                         |  |                                  |                     | 11.03                                 | T                  |                                     |              | DECEMBI                        |                      |                     | 2005                        | 1205                             | A M      |
|            | Examir   | er             | 4a. Facility Name (If not ins<br>MEMORIAL HC   | _                       |  | iber)                            |                     |                                       | nown, oi           | Location                            | of Death     |                                |                      | -                   | of Death<br>GANY            |                                  |          |
|            | Funeral  |                | 5. Social Security Number  |                         |  | 7. Age (In yrs.                  | last birthda        | y) If Under                           | 1 Year             | If Under                            | 24 Hrs.      | 8. Date of Bir                 | th                   |                     | 9. Birthp                   | ace (State or                    | Foreign  |
| 7          | Director   |                | 216-38-2160  |                         | 1 <b>X</b> M 2□F   | 86                               | Yrs.                | Months                                | Days               | Hours                               | Min.         | Month, Da                      | $\frac{1}{1}$        | 19                  | Mary                        |                                  |          |
|            | pun 🛦 .  |                | Usual Residence of Decede  |                         |  | 10c. Ci                          | tv. Town or         | Location                              |                    |                                     |              |                                |                      |                     | 1/                          | 0d. Inside Cit                   | / Limits |
|            | daryle<br>f sho  | ō              |  | rret                    | +  |                                  | iendsv              |                                       |                    |                                     |              |                                |                      |                     |                             | 1 🗆 Yes                          |          |
|            | 28e-   | Director       | 10e. Street and Number   |                         |  |                                  |                     | 10f. Zip                              | Code               |                                     |              |                                | 10g. Cit             | izen of V           | What Coun                   | try?                             |          |
|            | h with   |                | 2155 Friends   | vill                    | e Road   |                                  |                     | 21                                    | 531                |                                     |              |                                | USA                  | A                   |                             |                                  |          |
| 36         | d within 72 hours after death with the Maryland<br>jene.<br>Ir than "natural", or Items 23a or 28e-f show<br>It e Medical Evantiar must be notified at | by Funerai     | 11. Marital Status  1 □ Never Married 2  3 □ Widowed 4 □ Div   |                         | 12. Was Dece<br>Armed For<br>1 Tes<br>If Yes, Give<br>Year or Da | ces?<br>2 [ <b>X</b> No<br>e     | J.S. 13             | 8. Was Deced<br>If Yes, spec          | cify Cuba          | ispanic Or<br>n, Mexica<br>Specify: | n, Puerto F  | cify Yes or No<br>Rican, etc.) | )-                   |                     | e - America<br>ck, White, e |                                  |          |
| Š          | 2 hou  | ted            | 15. De   | cedent's E              | Education  |                                  | 16a. Dec            | edent's Usua                          | al Occupa          | ation                               |              |                                | 16b. K               | ind of Bu           | usiness/Ind                 |                                  |          |
| 21215-0036 | within 7<br>ene.<br>than "n  | Completed      | Elementary/Secondary (0  |                         | rade completed) College (1-                                      | 4or 5+)                          | life                | re kind of wo<br>. DO NOT u:          | se retired         | juring mos<br>()                    | st or workin | g                              |                      |                     |                             |                                  |          |
| 21         | filed wi<br>Il Hygien<br>other th  |                |  |                         |  |                                  | F'a                 | rming                                 |                    | 40.44-11                            | 4. 51        | /m**                           |                      |                     | lture                       |                                  |          |
| Maryland   | \$ 5 5 5 T   | To Be          | 17. Father's Name (First, M<br>James Clark   |                         |  |                                  |                     |                                       |                    |                                     |              | (First, Middle<br>Ann E        |                      |                     | 16)                         |                                  |          |
| Nar        | 2 as as  |                | 19a. Informant's Name/Rei  |                         |  |                                  |                     | •                                     |                    |                                     |              | Friend                         |                      |                     |                             | <sup>Содө)</sup><br><b>21531</b> |          |
|            | ss 1 and 2 should<br>of Health and Men<br>item 27 is marke<br>other traumatic  |                | Grace M. Rus   | 911/ VV T               | re   | 20b. I                           | _                   |                                       |                    |                                     |              | rtienc                         |                      |                     | City or Tox                 |                                  |          |
| Baltimore, | permit. Pages. Department of h Important: If ite any injury or of  |                | 1 XBurial 2 ☐ Crem   |                         |  | iaie                             |                     | position (Nar.<br>rematory or o       |                    | 1                                   |              |                                |                      |                     | -                           |                                  |          |
| 턡          | artme<br>ortani<br>injury  | H              | *4 ☐ Donation 5 ☐ Ott  |                         |  | Be                               |                     |                                       |                    | -                                   |              | 15, 20<br>man Fu               |                      |                     |                             |                                  | 1536     |
| Ba         | Depar<br>Impo<br>any ir  |                | 1 Dan  | Pa                      | may-   |                                  |                     |                                       |                    |                                     |              | Box 2                          |                      |                     |                             |                                  |          |
|            | <b>3</b> 0   |                | 23a. Part1. Enter the disea<br>shock, or heart ailure  | se, or con              | nplications that ca  | used the deat                    | th. Do not e        | nter the mod                          | le of dyin         | g, such as                          | cardiac or   | respiratory a                  | rrest,               |                     |                             | Approximate<br>Interval Betw     | een      |
|            | Physician  |                | Immediate Cause (Final disease or condition  |                         |  | CEREBRA                          | AL HEM              | АТОМА                                 |                    |                                     |              |                                |                      |                     |                             | Onset and De                     |          |
|            | /Medical<br>Examiner   |                | resulting in death)  | -                       |  | or as a consec                   |                     |                                       |                    |                                     |              |                                |                      |                     |                             |                                  |          |
|            | Lxammer  | _              | Sequentially list conditions, if any, leading to arranged at the conditions of the c |                         |  |                                  |                     |                                       |                    |                                     |              |                                |                      |                     |                             |                                  |          |
|            | ted<br>nsit  | Examiner       | The following control of the following cause. Enter Underlying Cause (Disease or Injury COLIMADIN TUEDADY  |                         |  |                                  |                     |                                       |                    |                                     |              |                                |                      |                     |                             |                                  |          |
|            | be executed<br>sician and<br>burial-transit  | xar            | that initiated events resulting in death) Last COUMADIN THERAPY  Due to (or as a consequence of):  |                         |  |                                  |                     |                                       |                    |                                     |              |                                |                      |                     |                             |                                  |          |
| 8760,      | ate be ex<br>nysician<br>he burial   | icai           |  | l                       | d  |                                  |                     |                                       |                    |                                     |              |                                |                      |                     |                             |                                  |          |
| 9          |  | e e            | 15.55111.5   |                         |  |                                  |                     |                                       |                    |                                     |              |                                |                      |                     |                             |                                  |          |
| Вох        | eath certific<br>attending p<br>I for use as I   | Physician/M    | IF FEMALE:<br>23b. Was decedent pregna<br>in the past 12 months'   |                         | 23c. If yes, outc  | ome of pregnath 2 Peta           |                     | □Ectopic pr                           | egnancy            |                                     |              |                                | 2                    | 23d. Date<br>Mor    | e of deliver                | y<br>Day Ye                      | nar.     |
|            | the all  | sici           | 1 ☐ Yes 2 ☐ No<br>9 ☐ Unknown  |                         | 4□Pregna<br>9□ Unkno   | nt at time of o                  | leath 5             | Other (sp                             | ecify)             |                                     |              |                                |                      | 14101               | 101                         | Jay 16                           | odi .    |
| P.0        | res that the de<br>signed by the a<br>I be detached f  |                | Part II. Other significant co  | nditions                | contributing to dea  | ath but not res                  | ulting in the       | underlying c                          | ause give          | n in Part I                         |              | 23e. Did t                     | obacco u             | se contr            | ribute to the               | a cause of de                    | ath?     |
| ds,        | uires<br>sign  | d by           | , and the second |                         | J  |                                  |                     | , ,                                   | J                  |                                     |              | 10                             | res 2                | No                  | 3 🗌 Proba                   | ibly 4 □Ur                       | known    |
| ecords,    | taw requires that<br>as been signed b<br>2 should be deta  | Completed      |  |                         |  |                                  |                     | · · · · · · · · · · · · · · · · · · · |                    |                                     |              | 24a. Was                       | an                   | 24b. V              | Vere autop                  | sy findings av                   | ailable  |
| $\alpha$   | 0 = 0  | omo            |  |                         |  |                                  |                     |                                       |                    |                                     |              | autor<br>perfo                 | rmed?<br>2 2 No      | p                   | rior to com<br>leath?       | ipletion of cau<br>2□ No         | use of   |
| Vital      | iclan: Th<br>certificate<br>rector, pag  | O              | 25. Was case referred to m   | edical                  |  |                                  |                     |                                       |                    | 26. Place                           | of Death     | (Check only o                  |                      | l                   |                             |                                  |          |
| of V       | di is  | To B           | examiner?<br>1 ☐ Yes 2 <b>X</b> No   |                         | Hospital: 1 1 In   | patient 2                        | ER/Outpati          | ent 3 DO                              | Othe               | er: 4 □ Nu                          | ırsing Hom   | e 5 🗆 Resid                    | dence 6              | 5 □Othe             | er (Specify)                |                                  |          |
| o u        | ding Ph<br>h.<br>After th<br>funeral   |                | 27. Manner of Death<br>1 Natural 5 ☐ F   | ending                  | 28a. Date of<br>(Month   | Injury<br>, Day Year)            | 28b. Time<br>Injury |                                       | 8c. Injury<br>Work |                                     |              | 3d. Describe h                 | now injur            | y occurre           | ed                          |                                  |          |
| Sio        | Attending r death. sctor: After by the funer   | icat           | 3 ☐ Suicide 6 ☐ C  | ould not b              | De Diago   | of Injune - At h                 | omo farm            | M<br>tract feeter                     |                    | ∕es 2□                              | -            | of Location //                 | Stenot an            | d Alumba            | ar ar Pumi                  | Courto Alcumba                   |          |
| Division   | or At<br>after d<br>Direct<br>in by  | Certification; | 4 Homicide   | etermined               | buildin  | of Injury - At high etc. (Specif | y)                  | treet, ractory                        | , onice            |                                     | 20           | 8f. Location (5<br>City or Tox | vn, State,           | )                   | er or nurar                 | HOUSE NUMBE                      | ar,      |
|            | To the Hospitel or Attent within 24 hours after death To the Funeral Director: completely filled in by the   | edical C       | 29a. Certifier 1 🔀 Ce<br>(Check only one) 2 🗌 Me   | rtifying P<br>dical Exa | hysician: To the t<br>miner: On the ba                           | sis of examina                   | wiedge, dea         | th occurred nvestigation,             | at the tim         | e, date an<br>inion, dea            | d place, ar  | nd due to the                  | cause(s)<br>date and | and mar<br>place, a | nner as sta<br>and due to   | ted.<br>the cause(s)             |          |
|            | o the  | Me             | 29b. Signature and title of c  | ertifier                | 3,74 (((3)))   |                                  |                     | 29c                                   | . License          | number                              |              |                                | 29d. Date            | e signed            | (Month, D                   | lay, Year)                       |          |
|            | - S - Ö  |                | > Thede  |                         | Ashl   | v i                              | MD                  | D                                     | 2647               | 1                                   |              |                                | DECI                 | EMBE                | R 13,                       | 2005                             |          |
|            |  |                | 30. Name and address of po   |                         |  | of death (Item<br>KENT A         |                     |                                       | RLAN               | D, MI                               | 2150         | 02                             |                      |                     |                             |                                  |          |
|            | Sta<br>Registr   |                | 31. Date filed (Month, Day,  |                         | 32. Re   | gistrar's Signa                  | ature               | Samuelle                              |                    |                                     |              |                                |                      |                     |                             |                                  |          |
|            |  |                |  |                         | - N A  |                                  | 400                 |                                       |                    |                                     |              |                                |                      |                     |                             |                                  |          |

|  |  |   | 1 - For State of Mary  |  | artment of<br>rtificate o             |                              |  | Reg. No. 200                   | 05-41999  |  |  |  |
|--|--|---|--|--|---------------------------------------|------------------------------|--|--------------------------------|---|--|--|--|
| S. A. S. S. S. S. S. S. S. S. S. S. S. S. S. | Physici<br>/Medio  |   | 1. Decedent's Name (First, Middle, Last)  Resley Eugene SPEAKER  |  |                                       |                              |  | er 13, 200                     |   |  |  |  |
|  | Examir   | er  | 4a. Facility Name (If not institution, give street and number) 436 Virginia Ave., Apt. 3   |  |                                       | n, or Location of            |  | 4c. County of                  |   |  |  |  |
|  |  |   |  | yrs. last birthday)                      | If Under 1 Ye                         | gerstown<br>ar If Under 2    | 4 Hrs.   9 Date of Bi                        | rth                            | ington  Birthplace (State or Foreign  |  |  |  |
|  | Funeral<br>Director  |   | 217-30-5891 1☼M 2□F 71   | Yrs.                                     | Months Day                            | ys Hours                     | Min. (Month, D                               | 3, 1934                        | Birthplace (State or Foreign<br>Country)<br>Maryland                        |  |  |  |
|  |  |   | Usual Residence of Decedent  |  |                                       |                              | 1- ,   | 1                              |   |  |  |  |
|  | show   |   |  | c. City, Town or Lo                      | ocation                               |                              |  |                                | 10d. Inşide City Limits<br>1 ☑ Yes 2 ☐ No                                   |  |  |  |
|  | Ba-f   | cto   | Maryland Washington  | Hage                                     | rstown                                |                              |  |                                |   |  |  |  |
|  | with th  | Ē   | 10e. Street and Number   |  | 10f. Zip Code                         |                              | ,  | 10g. Citizen of Wha            |   |  |  |  |
|  | eath<br>is 23  | Funeral Director  | 436 Virginia Avenue  11. Marital Status 12. Was Decedent Ever  | in U.S. 13                               | Was Decedent of                       | 21740                        |  |                                | SA<br>American Indian,  |  |  |  |
|  | fter d   | Fun   | Armed Forces?  1 Never Married 2 Married 1 Yes 2 XNo   | 1  |                                       |                              | in? (Specify Yes or N<br>Puerto Rican, etc.) | Black,                         | White, etc.   |  |  |  |
| 93   | urs a  | þ   | 3 ☐ Widowed 4 ☒ Divorced If Yes, Give Year or Dates:   |  | 1⊡Yes 2⊠XN                            | No Specify:                  |  | Specify:                       | white   |  |  |  |
| 21215-0036                                   | 72 hours after death with the Maryland<br>natural', or items 23a or 28a-f show<br>disell Exart met must be Lodiffed at | Completed   | 15. Decedent's Education (Specify only highest grade completed)  | 16a. Dece                                | dent's Usual Occ                      | cupation<br>ne during most o | of working                                   | 16b. Kind of Busin             | ness/Industry   |  |  |  |
| 2  | within<br>ene.<br>then "   | npie  | Elementary/Secondary (0-12) College (1-4or 5+)   |  | kind of work doi<br>DO NOT use ret    | rired)                       |  | _                              |   |  |  |  |
|  | a filed w<br>If Hygier<br>other th   |   | 12 0   | -  | laborer                               | 19 Mothor                    | s Name (First, Middle                        | furni                          | Lture   |  |  |  |
| Maryland                                     |  | o Be  | Resley Ellsworth Speaker   |  |                                       |                              | Elizabet                                     |                                | 2   |  |  |  |
| Z  | 2 should be and Mental is marked sumatic ev  | Ĕ   | 19a. Informant's Name/Relationship (Type, Print)   | per, City or Town, Sta                   |                                       |                              |  |                                |   |  |  |  |
|  | 1 and 2 s<br>Health ar<br>tem 27 is  |   | Roy Speaker - son  | 1780                                     | 07 Woody                              | ale Ct.                      | , Hagerst                                    | own, Md. 2                     | 21740   |  |  |  |
| altimore,                                    | s 1 a<br>of Hea<br>item<br>othe  |   | Total Modified on the Property of the Property | Ob. Place of Dispo                       | osition (Name of<br>matory or other p | olace)                       | Date   | 20c. Location - Cit            | ty or Town, State   |  |  |  |
| Ē  | Pages<br>nent of<br>ant: If it<br>ary or o   |   | 1X Burial 2 ☐ Cremation 3 ☐ Removal from State  '4 ☐ Donation 5 ☐ Other (Specify)  | Cedar Lav                                | wn Mem.                               | Park                         | 12/17/05                                     |                                | own, Maryland   |  |  |  |
| alt  | permit. Pages<br>Department of I<br>important: If its<br>any injury or o   |   | 21. Signature of Funeral Service Licensee  | 2  | 2. Name and Add                       |                              |  | H FUNERAL                      |   |  |  |  |
| 8  | 2072 201   |   | 23a. Part1. Enter the disease, or complications that caused the  | Me                                       |                                       |                              | Blvd., Hage                                  |                                | 1d. 21740   |  |  |  |
|  | Physician<br>/Medical<br>Examiner  | Examiner  | shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury   |  | Cunce                                 |                              |  |                                | Interval Between<br>Onset and Death<br>Y Mun Th                             |  |  |  |
| x 68760,                                     | death certificate be executed<br>e attending physician and<br>of for use as the buriat-transit                         | dicai   | resulting in death) Last  C. Due to (or as a co  |  |                                       |                              |  |                                |   |  |  |  |
| .O. Box                                      | the death c<br>by the attenc<br>ached for us   | Physician/Me  | 23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown  23c. If yes, outcome of p 1 Live birth 2  4 Pregnant at time 9 Unknown  | Fetal death 3                            | Ectopic pregnal Other (specify)       |                              |  | 23d. Date o<br>Month           |   |  |  |  |
| rds, P.                                      | law requires that the de<br>as been signed by the s<br>2 should be detached t  | by  | Part II. Other significant conditions contributing to death but no   | ot resulting in the u                    | nderlying cause                       | given in Part I.             |  | /                              | ite to the cause of death?  ☐ Probably 4 ☐ Unknown                          |  |  |  |
| of Vital Records,                            | The<br>ate h<br>page   | Completed   |  |  |                                       |                              | 24a. Was<br>auto<br>perf<br>1 🗆 Yes          | ppsy prio<br>ormed? dea        | re autopsy findings available r to completion of cause of th? Yes 2 \sum No |  |  |  |
| Vita   | ilclen: Th<br>certificate<br>rector, pag   | Be  | 25. Was case referred to medical examiner?   |  |                                       | Other                        | of Death (Check only                         |                                |   |  |  |  |
| on of \                                      | ling Phys<br><br>After this<br>uneral di   | 1   Inpatient 2   E-Proutpatient 3   DOA   4   Nursing Home 5   Hesidence 6   Other (Specify) |  |  |                                       |                              |  |                                |   |  |  |  |
| Division                                     | ist or Attending s after death. st Director: After at in by the fune   | Certification:  | e □ e i i i e ∈ □ Could not be   | At home, farm, str<br>pecify)            | reet, factory, office                 | се                           |  | (Street and Number own, State) | or Rural Route Number,  |  |  |  |
|  | To the Hospital within 24 hours a to the Funeral I completely filled   | edicai  | 29a. Certifier (Check only one)  1 Certifying Physician: To the best of m 2 Medical Examiner: On the basis of examiner stated.   | y knowledge, deati<br>mination and/or in | vestigation, in m                     | y opinion, death             | place, and due to the occurred at the time.  | , date and place, and          | I due to the cause(s)   |  |  |  |
|  | To   | Σ   | 29b. Signature and title of certifier  |  | 29c. Lice                             | ense number                  |  | 29d. Date signed (A            | Month, Day, Year)   |  |  |  |
| 1  | MD   |   | I metal y. Mulou   | 1/11/                                    | 0                                     | 7166                         | /  | 12.1                           | 1 05  |  |  |  |
|  | 1  |   | 30. Name and address of person who completed cause of death  Michael McComac'k  31. Date filed (Month, Day, Year)  32. Registrar's:  | (Item 23a) (Type,                        | Print)                                | 11                           | 1  | 12. 1                          | 110 110   |  |  |  |
|  | Sta  | ite.  | 31. Date filed (Month, Day, Year) 32. Registrar's  | Signature                                | A all                                 | 11100                        | umus   | Majerire                       | wy Irw  |  |  |  |
|  | Regist   |   | DEC 1 @ 2005   | 1 D. P.                                  | parael                                |                              |  |                                |   |  |  |  |

|                 |  | •                 | 1 - For<br>State<br>Registrar   | State of I   | Marylar                       |                        |             |                     | lealth a<br>Death    |              | R  | 9 No. []       |                    | ,201                           | 00          |
|-----------------|--|-------------------|---|--|-------------------------------|------------------------|-------------|---------------------|----------------------|--------------|--|----------------|--------------------|--------------------------------|-------------|
| 7               | Physici  | an                | Decedent's Name (First, Middle, L   |  |                               |                        |             |                     |                      | 2            | <ol><li>Date of Deat<br/>Month</li></ol> | h<br>Day       | Year               | 3. Time                        | of Death    |
|                 | /Medi  |                   |   | ayian  |                               |                        |             |                     |                      |              | ecember                                  | T              | 005                | 10:10                          | а м         |
|                 | Examir   | ier               | 4a. Facility Name (If not institution, gi   |  | er)                           |                        | 1           |                     | Location of          | f Death      |  | 4c. County     |                    |                                |             |
|                 | V 1. 18  | ×                 | 5121 Trailway D   |  |                               |                        |             | ockv:               | IIIe                 | 04 Hrs   a   | Date of Blat                             |                | gome               |                                | -           |
| ı               | Funeral Director   |                   | 012-34-9329   | Sex 7.<br>1 □ M 21X F  | Age (in yrs.                  | last birthday)<br>Yrs. | Months      |                     | Hours                | Min.         | B. Date of Birth (Month, Day, Ct. 25,    | Year)          | Col                | place (State<br>intry)<br>nada | or Foreign  |
|                 | and w  |                   | Usual Residence of Decedent  10a. State 10b. County                                     |  | 10c. Cit                      | ty, Town or Lo         | cation      |                     |                      |              |  |                |                    | 10d. Inside                    | City Limits |
|                 | anyla eho  | 5                 | Maryland Montgo   | merv   | Ro                            | ockvill                | 6           |                     |                      |              |  |                |                    | 1 ☐ Ye                         | s 2X No     |
|                 | 28a-i  | ect               | 10e. Street and Number  |  |                               |                        | _           | o Code              | _                    |              | 1  | 0g. Citizen of | What Cou           | intry?                         |             |
|                 | with sa or   | 0                 | 5121 Trailway Dr  | ive  |                               |                        | 208         |                     |                      |              |  | USA            |                    |                                |             |
|                 | 72 hours after death with the Maryland<br>natural', or iteme 23a or 28a-1 ehow<br>iteal Examiner must be notified at                     | Funeral Director  | 11. Marital Status  | 12. Was Decede   |                               | I.S. 13.               | Was Dece    | dent of H           | spanic Orig          | gin? (Speci  | ify Yes or No-<br>ican, etc.)            |                |                    | ican Indian,                   |             |
| <b>'</b> O      | ritter   | F.                | 1 Never Married 2 Married   | Armed Force  |                               |                        |             |                     |                      | , Puerto Ri  | can, etc.)                               |                | ck, White          |                                |             |
| 03              | urs a  |                   | 3 ☐ Widowed 4 ☐ Divorced  | If Yes, Give<br>Year or Date                                       | s:                            |                        | 1 🗌 Yeş     | 2 X No              | Specify:             |              |  | Specif         | y:Whi              | ce                             |             |
| 21215-0036      | 72 hours<br>"natural",<br>alcal Em   | Completed by      | 15. Decedent's 6<br>(Specify only highest g   |  |                               | 16a. Dece              |             |                     | ation<br>during most | of working   | 1  | 16b. Kind of B | usine <i>s</i> s/l | ndustry                        |             |
| 21              | c * W  | p<br>jd           | Elementary/Secondary (0-12)   | College (1-4   | or 5+)                        | life.                  | DO NOT L    | se retired          | )                    |              |  |                |                    |                                |             |
| 2               | filed within I Hygiene. other then   | S                 | 12  |  |                               | Hon                    | nemak       | er                  |                      | 4 /          | =  | 4 :            |                    | Home                           |             |
| Maryland        | be filed<br>tal Hyg<br>d othe<br>event,  | Be                | 17. Father's Name (First, Middle, Las   |  |                               |                        |             |                     |                      |              | First, Middle, I                         |                | ne)                |                                |             |
| <del>y</del> la | should be<br>and Mental<br>s marked o  | ို                | Kapriel Ohennes   |  |                               |                        |             | 1                   |                      |              | olasari                                  |                |                    |                                |             |
| lar             | 2 sh<br>and<br>is m  |                   | 19a. Informant's Name/Relationship  | (Type, Print)  |                               |                        |             |                     |                      |              | Route Number                             | 11770          | State, Zi          | p Code)                        |             |
| 6               | and<br>lealth<br>m 27<br>her t   |                   | Vaughn Santig S   | ayian/Hus  | band                          | 5121<br>Place of Dispo |             | THE REAL PROPERTY.  | Drive                | e, Roe       | ckville                                  | 20c. Location  | 2085               |                                |             |
| 0               | 100 = 20 P   |                   | 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3                                   | Removal from Sta   | ite                           | cemetery, crei         | natory or o | other plac          |                      | ecemb        | er 14                                    | 200. LUCATION  | · City of i        | OWII, State                    |             |
| Ë               | tent:  |                   | 4 □Donation 5 □ Other (Spec   |  | Gat                           | e of Hea               |             |                     |                      | 200          |  | Silver         |                    | ng, Mar                        | yland       |
| Baltimore,      | permit. Pages 1 and 2 should be<br>Department of Health and Menta<br>Important: If Item 27 is marked<br>any Injury or other traumatic ev |                   | 21. Signature of Funeral Service Lieu   | Scent  | 0                             |                        |             |                     |                      |              | uneral<br>W, Sil                         |                |                    | , MD 2                         | 20901       |
|                 | å og   |                   | 23a. Part1. Enter the disease, or con<br>shock, or heart failure. List on               | pplications that cau   | sed the deat<br>n line.       | th. Do not ent         | er the mod  | de of dyin          | g, such as o         | cardiac or i | respiratory arre                         | est,           |                    | Approxim<br>Interval B         | etween      |
| ķ               | Physician  |                   | Immediate Cause (Final disease or condition   | Arrhy  | thmia                         |                        |             |                     |                      |              |  |                |                    | Onset and                      | Death       |
| 4               | /Medical   |                   | resulting in death)   | Due to (or   | as a consec                   | quence of):            |             |                     |                      |              |  |                |                    |                                |             |
|                 | Examiner   |                   | Sequentially list conditions,   |  |                               | Infarc                 | tion        |                     |                      |              |  |                |                    |                                |             |
|                 | D ≅  | ner               | if any, leading to infinidiate cause. Enter Underlying Cause (Disease or injury         | Due to (or   | as a eurisau                  | juence offr            |             |                     |                      |              |  |                |                    |                                |             |
| 8760,           | ate be executed thysicien and the burial-transit   | ical Examiner     | Cause (Disease or injury that initiated events resulting in death) Last                 | G.   | ary Ar<br>as a conseq         | rtery D                | isea        | se<br>              |                      |              |  |                |                    |                                |             |
| O. Box 6        | The law requires that the death certifics tie has been signed by the attending pt page 2 should be detached for use as it                | Physician/Medical | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown | 23c. If yes, outcon<br>1 □Live birth<br>4 □ Pregnan<br>9 □ Unknown | 2 ☐ Feta<br>t at time of c    | aldeath 3              | Ectopic p   |                     |                      |              |  |                | te of deliventh    | very<br>Day                    | Year        |
| О.              | s that<br>ned b<br>e deta  | by Pi             | Part II. Other significant conditions   | contributing to deat   | h but not res                 | sulting in the u       | nderlying ( | cau <i>s</i> e give | en in Part I.        |              | 23e. Did tob                             | acco use con   | tribute to         | the cause of                   | death?      |
| rds             | quires<br>n sign<br>ald be   |                   | High Blood Press  | sure, Hyp  | erlipi                        | idemia,                |             |                     |                      |              | XXXY6                                    | is 2□No        | 3 ☐ Pro            | bably 4                        | ]Unknown    |
| Records,        | w requires si should is  | Completed         | Hypothyroidism  |  | _                             |                        |             |                     |                      |              | 24a. Was a                               |                | Were aut           | opsy finding                   | s available |
| Re              | The lar  | 뻝                 |   |  |                               |                        |             |                     |                      |              | autops                                   | ned?           | death?             | ompletion of                   | cause of    |
| Vital           |  | ပိ                | 25. Was case referred to medical  |  |                               |                        |             |                     | 26 Place             | of Death /   | 1 Yes 2 Check only on                    |                | 1 🗌 Yes            | 2 140                          |             |
| Ē               | Physicien:<br>this certificant director,   | To B              | examiner?<br>1x Yes 2 □ No  | Hospital:  | atient 2                      | ER/Outpatier           | nt 3 🗆 D    | Othe                | - C                  | •            | ∍ 5 <b>X</b> Reside                      |                | er (Spec           | (fv)                           |             |
| of              |  |                   | 27. Manner of Death   | 28a. Date of I<br>(Month,  |                               | 28b. Time of           |             | 28c. Injun          |                      |              | d. Describe ho                           |                |                    | -97                            |             |
| on              | th.<br>: After<br>e funer  | i i               | 1 ☐Natural 5 ☐ Pending 2 ☐ Accident investigation                                       |  | Day Year)                     | Injury                 | М           |                     | Yes 2□N              | No           |  |                |                    |                                |             |
| Division        | of afterding after death.  Director: After d in by the fune  | Certification:    | 3 Suicide 6 Could not determine   | d 280. Place of  | Injury - At h<br>etc. (Specia | ome, farm, str<br>fy)  | eet, factor | y, office           |                      | 28           | f. Location (St.<br>City or Town         |                | er or Rui          | al Route Nu                    | mber,       |
|                 | To the Hospitel or within 24 hours after To the Funeral Director completely filled in b  | edical C          |   | hysician: To the be  | s of examina                  |                        |             |                     |                      |              |  |                |                    |                                | (s)         |
|                 | To the<br>within<br>To the   | ₩<br>E            | 29b. Signature and title of certifier   |  | 5                             |                        | 29          | c. License          | number               |              | 25                                       | 9d. Date signe | d (Month           | Day, Year)                     |             |
| 1               |  |                   | ) JAN   | Adu  | a r                           | ND                     |             |                     | 10493                | }            |  | Decembe        | er 13              | 3, 200                         | 5           |
|                 | 10   |                   | 30. Name and address of person who  | completed cause of   | of death (Iter                | n 23a) (Type.          | Print)      |                     |                      |              |  |                |                    |                                |             |
|                 |  |                   | John Saia, M.D.   | 1201 Seve  |                               |                        |             | 202,                | Rockv                | ille,        | MD 20                                    | 851            |                    |                                |             |
|                 | Sta  |                   | 31. Date filed (Month, Day, Year)   | 32 Reg   | strar's Signa                 | ature                  | ule)        |                     |                      |              |  |                |                    |                                |             |
|                 | Registr  | ar                | DEC 13 2  | 005  | 10 - 6                        | A ASS                  | 1984        |                     |                      |              |  |                |                    |                                |             |